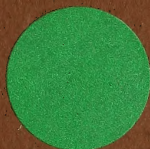


**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XX
97th Congress
1981-1982**



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Legislative History of Titles I-XX of the Social Security Act

**Volume XX
97th Congress
1981-1982**

Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
Office of Regulations
Office of Operational Policy and Procedures
Social Security Administration

PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the provisions of the Social Security Act as amended by the 97th Congress, which adjourned on December 23, 1982.

The legislative history began with the Social Security Act, as enacted on August 14, 1935, and pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Beginning with the legislative history of the 95th Congress, the history has been expanded to include the 20 titles of the Social Security Act.

This legislative history includes:

- . Every enactment of the 97th Congress amending the Social Security Act.
- . Relevant committee reports of the House of Representatives and the Senate relating to the Social Security Act together with the Conference Reports.

Excerpts were substituted for the full text where pertinent.

In some instances the reports accompanying a particular act will not reflect one or more provisions contained in the Act. This may be due to the fact that the particular provision was added to the bill on the floor of the House, or Senate, as the case may be, after issuance of the particular report or the particular subject matter involved simply was not included in the report of the committee proceedings. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the acts included in this history. However, on the last page of each public law contained in this volume, appears a listing of the dates on which the act was considered in the House and Senate, and the volume of the Congressional Record in which such debate may be found.

The material included in this legislative history is an exact photo-reproduction of the original documents.

Finder's Aid
P.L. 97-34 (95 Stat. 172) Approved August 13, 1981
"Economic Recovery Tax Act of 1981"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>95 Stat.</u>	<u>H.Rep. 97-201</u>	<u>S.Rep. 97-144</u>	<u>H.C.Rep. 97-215*</u>
Wages--Exclusions from Income-- Dependent Care Assistance	209(q)	124(e)(2)(B)	201	--	--	201
Employee Tax Liability (Conforming Amendment--IRC-RRB)	230(c)	741(d)(1)(A)	347	254	--	265
Employee Tax Liability-- (Conforming Amendment--IRC-RRB)	230(c)	741(d)(1)(B)	347	254	--	265
Employee Tax Liability-- (Conforming Amendment--IRC-RRB)	230(c)	741(d)(1)(C)	347	254	--	265

* Senate Conference Report 97-176 is identical.

ECONOMIC RECOVERY TAX ACT OF 1981

Public Law 97-34
97th Congress

An Act

Aug. 13, 1981
[H.R. 4242]

To amend the Internal Revenue Code of 1954 to encourage economic growth through reduction of the tax rates for individual taxpayers, acceleration of capital cost recovery of investment in plant, equipment, and real property, and incentives for savings, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Economic
Recovery Tax
Act of 1981.
26 USC 1 note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; AMENDMENT OF 1954 CODE.

(a) **SHORT TITLE.**—This Act may be cited as the “Economic Recovery Tax Act of 1981”.

(b) **TABLE OF CONTENTS.**—

Sec. 1. Short title; table of contents; amendment of 1954 Code.

TITLE I—INDIVIDUAL INCOME TAX PROVISIONS

Subtitle A—Tax Reductions

- Sec. 101. Rate cuts; rate reduction credit.
- Sec. 102. 20-percent maximum rate on net capital gain for portion of 1981.
- Sec. 103. Deduction for two-earner married couples.
- Sec. 104. Adjustment to prevent inflation-caused tax increase.

Subtitle B—Income Earned Abroad

- Sec. 111. Partial exclusion for earned income from sources without the United States and foreign housing costs.
- Sec. 112. Repeal of deduction for certain expenses of living abroad.
- Sec. 113. Employees living in camps.
- Sec. 114. Reports by Secretary.
- Sec. 115. Effective date.

Subtitle C—Miscellaneous Provisions

- Sec. 121. Deduction for charitable contributions to be allowed for individuals who do not itemize deductions.
- Sec. 122. 18-month periods for rollover of principal residence increased to 2 years.
- Sec. 123. One-time exclusion of gain increased to \$125,000.
- Sec. 124. Increases in credit allowable for expenses for household and dependent care services necessary for gainful employment.
- Sec. 125. Deduction for adoption expenses paid by an individual.
- Sec. 126. Maximum rate of imputed interest for sale of land between related persons.
- Sec. 127. State legislators travel expenses away from home.
- Sec. 128. Rates of tax for principal campaign committees.

TITLE II—BUSINESS INCENTIVE PROVISIONS

Subtitle A—Cost Recovery Provisions

- Sec. 201. Accelerated cost recovery system.
- Sec. 202. Election to expense certain depreciable business assets.
- Sec. 203. Amendments related to depreciation.
- Sec. 204. Recapture on disposition of recovery property.

- Sec. 205. Minimum tax treatment.
- Sec. 206. Earnings and profits.
- Sec. 207. Extension of carryover period for net operating losses and certain credits.
- Sec. 208. Carryover of recovery attribute in section 381 transactions.
- Sec. 209. Effective dates.

Subtitle B—Investment Tax Credit Provisions

- Sec. 211. Modification of investment tax credit to reflect accelerated cost recovery.
- Sec. 212. Increase in investment tax credit for qualified rehabilitation expenditures.
- Sec. 213. Investment credit for used property; increase in dollar limit.
- Sec. 214. Investment tax credit allowed for certain rehabilitated buildings leased to tax-exempt organizations or to governmental units.

Subtitle C—Incentives for Research and Experimentation

- Sec. 221. Credit for increasing research activities.
- Sec. 222. Charitable contributions of scientific property used for research.
- Sec. 223. Suspension of regulations relating to allocation under section 861 of research and experimental expenditures.

Subtitle D—Small Business Provisions

- Sec. 231. Reduction in corporate rate taxes.
- Sec. 232. Increase in accumulated earnings credit.
- Sec. 233. Subchapter S shareholders.
- Sec. 234. Treatment of trusts as subchapter S shareholders.
- Sec. 235. Simplification of LIFO by use of Government indexes to be provided by regulations.
- Sec. 236. Three-year averaging permitted for increases in inventory value.
- Sec. 237. Election by small business to use one inventory pool when LIFO is elected.

Subtitle E—Savings and Loan Associations

- Sec. 241. Reorganizations involving financially troubled thrift institutions.
- Sec. 242. Limitations on carryovers of financial institutions.
- Sec. 243. Reserves for losses on loans.
- Sec. 244. FSLIC financial assistance.
- Sec. 245. Mutual savings banks with capital stock.
- Sec. 246. Effective dates.

Subtitle F—Stock Options, Etc.

- Sec. 251. Stock options.
- Sec. 252. Property transferred to employees subject to certain restrictions.

Subtitle G—Miscellaneous Provisions

- Sec. 261. Adjustments to new jobs credit.
- Sec. 262. Section 189 made inapplicable to low-income housing.
- Sec. 263. Increase in deduction allowable to a corporation in any taxable year for charitable contributions.
- Sec. 264. Amortization of low-income housing.
- Sec. 265. Deductibility of gifts by employers to employees.
- Sec. 266. Deduction for motor carrier operating authority.
- Sec. 267. Limitation on additions to bank loss reserves.

TITLE III—SAVINGS PROVISIONS

Subtitle A—Interest Exclusion

- Sec. 301. Exclusion of interest on certain savings certificates.
- Sec. 302. Partial exclusion of interest.

Subtitle B—Retirement Savings Provisions

- Sec. 311. Retirement savings.
- Sec. 312. Increase in amount of self-employed retirement plan deduction.
- Sec. 313. Rollovers under bond purchase plans.
- Sec. 314. Miscellaneous provisions.

Subtitle C—Reinvestment of Dividends in Public Utilities

- Sec. 321. Encouragement of reinvestment of dividends in the stock of public utilities.

Subtitle D—Employee Stock Ownership Provisions

- Sec. 331. Payroll-based credit for establishing employee stock ownership plan.
 Sec. 332. Termination of the portion of the investment credit attributable to employee plan percentage.
 Sec. 333. Tax treatment of contributions attributable to principal and interest payments in connection with an employee stock ownership plan.
 Sec. 334. Cash distributions from an employee stock ownership plan.
 Sec. 335. Put option for stock bonus plans.
 Sec. 336. Put option requirements for banks; put option period.
 Sec. 337. Distribution of employer securities from a tax credit employee stock ownership plan in the case of a sale of employer assets or stock.
 Sec. 338. Pass through of voting rights on employer securities.
 Sec. 339. Effective date.

TITLE IV—ESTATE AND GIFT TAX PROVISIONS

Subtitle A—Increase in Unified Credit; Rate Reduction; Unlimited Marital Deduction

- Sec. 401. Increase in unified credit.
 Sec. 402. Reduction in maximum rates of tax.
 Sec. 403. Unlimited marital deduction.

Subtitle B—Other Estate Tax Provisions

- Sec. 421. Valuation of certain farm, etc., real property.
 Sec. 422. Coordination of extensions of time for payment of estate tax where estate consists largely of interest in closely held business.
 Sec. 423. Treatment of certain contributions of works of art, etc.
 Sec. 424. Gifts made within 3 years of decedent's death not included in gross estate.
 Sec. 425. Basis of certain appreciated property transferred to decedent by gift within one year of death.
 Sec. 426. Disclaimers.
 Sec. 427. Repeal of deduction for bequests, etc., to certain minor children.
 Sec. 428. Postponement of generation-skipping tax effective date.
 Sec. 429. Credit against estate tax for transfer to Smithsonian.

Subtitle C—Other Gift Tax Provisions

- Sec. 441. Increase in annual gift tax exclusion; unlimited exclusion for certain transfers.
 Sec. 442. Time for payment of gift taxes.

TITLE V—TAX STRADDLES

- Sec. 501. Postponement of recognition of losses, etc.
 Sec. 502. Capitalization of certain interest and carrying charges in the case of straddles.
 Sec. 503. Regulated futures contracts marked to market.
 Sec. 504. Carryback of losses from regulated futures contracts to offer prior gains from such contracts.
 Sec. 505. Certain governmental obligations issued at discount treated as capital assets.
 Sec. 506. Prompt identification of securities by dealers in securities.
 Sec. 507. Treatment of gain or loss from certain terminations.
 Sec. 508. Effective dates.
 Sec. 509. Election for extension of time for payment and application of section 1256 for the taxable year including June 23, 1981.

TITLE VI—ENERGY PROVISIONS

Subtitle A—Changes in Windfall Profit Tax

- Sec. 601. \$2,500 royalty credit for 1981; exemption for 1982 and thereafter.
- Sec. 602. Reduction in tax imposed on newly discovered oil.
- Sec. 603. Exempt independent producer stripper well oil.
- Sec. 604. Exemption from windfall profit tax of oil produced from interests held by or for the benefit of residential child care agencies.

Subtitle B—Miscellaneous Provision

- Sec. 611. Application of credit for producing natural gas from a nonconventional source with the Natural Gas Policy Act of 1978.

TITLE VII—ADMINISTRATIVE PROVISIONS

Subtitle A—Prohibition of Disclosure of Audit Methods

- Sec. 701. Prohibition of disclosure of methods for selection of tax returns for audits.

Subtitle B—Changes in Interest Rate for Overpayments and Underpayments

- Sec. 711. Changes in rate of interest for overpayments and underpayments.

Subtitle C—Changes in Certain Penalties and in Requirements Relating to Returns

- Sec. 721. Changes in penalties for false information with respect to withholding.
- Sec. 722. Additions to tax in the case of valuation overstatements, increase in negligence penalty.
- Sec. 723. Changes in requirements relating to information returns.
- Sec. 724. Penalty for overstated deposit claims.
- Sec. 725. Declaration of estimated tax not required in certain cases.

Subtitle D—Cash Management

- Sec. 731. Cash management.

Subtitle E—Financing of Railroad Retirement System.

- Sec. 741. Increases in employer and employee taxes.
- Sec. 742. Advance transfer of amounts payable under social security financial inter-change.
- Sec. 743. Amendments to section 3231 clarifying definition of compensation.

Subtitle F—Filing Fees

- Sec. 751. Fees for filing petitions.

TITLE VIII—MISCELLANEOUS PROVISIONS

Subtitle A—Extensions

- Sec. 801. Fringe benefits.
- Sec. 802. Exclusion for prepaid legal services 3 years.

Subtitle B—Tax-Exemption Obligations

- Sec. 811. Tax-exempt financing for vehicles used for mass commuting.
- Sec. 812. Obligations of certain volunteer fire departments.

Subtitle C—Excise Taxes

- Sec. 821. Extension of telephone excise tax.
- Sec. 822. Exclusion of certain services from Federal Unemployment Tax Act.
- Sec. 823. Private foundation distributions.

Subtitle D—Other Provisions

- Sec. 831. Technical amendments relating to dispositions of investment in United States real property.
- Sec. 832. Modification of foreign investment company provisions.

Unemployment Tax Act), and section 3401(a)(19) (relating to collection of income tax at source on wages) and inserting in lieu thereof "section 127 or 129". 26 USC 3401.

(B) SOCIAL SECURITY ACT.—Subsection (q) of section 209 of the Social Security Act (defining wages) is amended by striking out "section 127" and inserting in lieu thereof "section 127 or 129". 42 USC 409.

(f) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 1981.

(2) The amendments made by subsection (e)(2) shall apply to remuneration paid after December 31, 1981.

26 USC 44A
note.

SEC. 125. DEDUCTION FOR ADOPTION EXPENSES PAID BY AN INDIVIDUAL.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals), as amended by section 103, is amended by redesignating section 222 as section 223 and by inserting after section 221 the following new section:

Ante, p. 187.

"SEC. 222. ADOPTION EXPENSES.

26 USC 222.

"(a) ALLOWANCE OF DEDUCTION.—In the case of an individual, there shall be allowed as a deduction for the taxable year the amount of the qualified adoption expenses paid or incurred by the taxpayer during such taxable year.

"(b) LIMITATIONS.—

"(1) MAXIMUM DOLLAR AMOUNT.—The aggregate amount of adoption expenses which may be taken into account under subsection (a) with respect to the adoption of a child shall not exceed \$1,500.

"(2) DENIAL OF DOUBLE BENEFIT.—

"(A) IN GENERAL.—No deduction shall be allowable under subsection (a) for any expense for which a deduction or credit is allowable under any other provision of this chapter.

"(B) GRANTS.—No deduction shall be allowable under subsection (a) for any expenses paid from any funds received under any Federal, State, or local program.

"(c) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED ADOPTION EXPENSES.—The term 'qualified adoption expenses' means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs by the taxpayer and which are not incurred in violation of State or Federal law.

"(2) CHILD WITH SPECIAL NEEDS.—The term 'child with special needs' means a child with respect to whom adoption assistance payments are made under section 473 of the Social Security Act."

(b) CONFORMING AMENDMENT.—The table of sections for such part VII is amended by striking out the item relating to section 222 and inserting in lieu thereof the following:

"Sec. 222. Adoption expenses.

"Sec. 223. Cross references."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1980.

26 USC 222
note.

“(i) the tax shown on the return for the taxable year,
or

“(ii) if no return was filed, the tax for such year.

“(C) **APPLICABLE PERCENTAGE.**—For purposes of subparagraph (B), the applicable percentage shall be determined in accordance with the following table:

If the taxable year begins in:	The applicable percentage is:
1982	65
1983	75.”

(b) **CLERICAL AMENDMENT.**—The heading of subsection (h) of section 6655 (relating to failure by corporations to pay estimated income tax) is amended by striking out “AT LEAST 60 PERCENT” and inserting in lieu thereof “MINIMUM PERCENTAGE”.

26 USC 6655.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1981.

26 USC 6655
note.

Subtitle E—Financing of Railroad Retirement System

SEC. 741. INCREASES IN EMPLOYER AND EMPLOYEE TAXES.

(a) **TAX ON EMPLOYEES.**—Section 3201 (relating to rate of tax on employees) is amended by striking out all that precedes “the rate of the tax” and inserting in lieu thereof the following:

26 USC 3201.

“(a) In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to 2.0 percent of so much of the compensation paid in any calendar month to such employee for services rendered by him as is not in excess of an amount equal to one-twelfth of the current maximum annual taxable ‘wages’ as defined in section 3121 for any month.

“(b) The rate of tax imposed by subsection (a) shall be increased by”.

(b) **TAX ON EMPLOYEE REPRESENTATIVES.**—Subsection (a) of section 3211 (relating to tax on employee representatives) is amended by striking out “9.5” and inserting in lieu thereof “11.75”.

26 USC 3211.

(c) **TAX ON EMPLOYERS.**—The first sentence of section 3221(a) (relating to tax on employers) is amended by striking out “9.5” and inserting in lieu thereof “11.75”.

26 USC 3221.

(d) **CONFORMING AMENDMENTS.**—

(1) The last sentence of section 230(c) of the Social Security Act is amended—

42 USC 430.

(A) by inserting “employee and” before “employer”,

(B) by striking out “section 3221(a)” and inserting in lieu thereof “sections 3201(a) and 3221(a)”, and

(C) by striking out “9.5” and inserting in lieu thereof “11.75”.

(2) Paragraph (1) of section 3231(e) (defining compensation) is amended by striking out “(iii)” and all that follows through “(iv)” and inserting in lieu thereof “or (iii)”.

26 USC 3231.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to compensation paid for services rendered after September 30, 1981.

26 USC 3201
note.

26 USC 1246
note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to sales or exchanges after the date of the enactment of this Act in taxable years ending after such date.

Approved August 13, 1981.

LEGISLATIVE HISTORY—H.R. 4242 (H.J. Res. 266):

HOUSE REPORTS: No. 97-201 (Comm. on Ways and Means) and No. 97-215 (Comm. of Conference).

SENATE REPORTS: No. 97-144 accompanying H.J. Res. 266 (Comm. on Finance) and No. 97-176 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 127 (1981):

May 21, H.J. Res. 266 considered and passed House.

July 29, H.R. 4242 considered and passed House.

May 21, July 15-18, 20-24, 27-29, H.J. Res. 266 considered in Senate.

July 31, H.R. 4242 considered and passed Senate, amended, in lieu of H.J. Res. 266.

Aug. 1, 3, Senate considered and agreed to conference report.

Aug. 4, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 17, No. 33 (1981):

Aug. 13, Presidential statement.

TAX INCENTIVE ACT OF 1981

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 4242

together with

ADDITIONAL, MINORITY, AND ADDITIONAL
DISSENTING VIEWS



JULY 24, 1981.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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E. Railroad Retirement Revenue Provisions

1. Increases in tier-II railroad retirement taxes (sec. 741 of the bill and secs. 3201, 3211, and 3221 of the Code)

Overview

The railroad retirement system is a Federally legislated retirement system covering employees in the railroad industry, with benefits and financing partially intertwined with the social security program. Credits are secured by employment in the railroad industry and financed through a combination of employee, employer, and Federal Government contributions to a trust fund. Slightly more than 1 million beneficiaries received payments totaling over \$4.7 billion in fiscal year 1980.

Under present law, the flow of revenue from railroad retirement taxes is inadequate to finance existing benefit levels. The current yearly deficit is nearly \$835 million and is expected to continue to be of that order of magnitude. The need to restore a measure of financial soundness to the system is urgent; the administration and the Congressional Budget Office predict that, under existing law, insufficient balances to issue full benefit payments may occur in the Railroad Retirement Account as early as spring of 1982.

The current structure of the railroad retirement system stems from a reorganization enacted in 1974. The 1974 Railroad Retirement Act established three benefit components. The system was divided into two "tiers," one of which roughly approximates social security (tier I), and the other, an industry staff retirement benefit (tier II). The first tier pays benefits based upon combined railroad industry and any social security covered earnings, and is financed by a tax on employers and employees on the same basis as social security. The second tier is related to service in the railroad industry and is financed by taxes on industry employers. The industry pension tier-II component is a principal factor causing the system's financial problems. The third component preserved certain "windfalls" for employees who had qualified for both Railroad Retirement and Social Security benefits prior to the 1974 Act. The phaseout of these windfalls was to be financed by level general revenue payments to the Railroad Retirement Account through the attrition of eligible beneficiaries.

It is estimated that the Railroad Retirement Account will run into cash flow problems in the spring of 1982. The shortfall is expected to be temporarily alleviated by that year's financial interchange with Social Security, but would recur in the spring of 1983, with complete insolvency predicted within two years after that.

Several factors contribute to a cash flow problem for the Railroad Retirement Account. First, because of differences between Social Security and Railroad Retirement Tier I benefits, Tier I disbursements are inadequately financed by the matching employer/employee Tier I tax and the Social Security interchange payment. Second, Tier II is inadequately financed by the current employer tax rate for those benefits. Third, the Railroad Retirement Account experience for wind-

fall benefit payments exceeds reimbursement from the Federal Government. Fourth, because reserves are being depleted, interest on invested reserves is a declining source of revenues to the fund. Finally, over the life of the Railroad Retirement system, there has been a steady increase in the number of beneficiaries, while the number of employees has fallen. Although the relationship of employees to beneficiaries has apparently stabilized (and the trend will actually reverse, probably by the end of the decade), the experience over the last few decades of a falling employee-to-beneficiary ratio has meant lower revenue to the fund during a time of increasing demand for payment.

Traditionally, because management and labor are affected by Federal decisions in railroad retirement, both have been given leading roles in the development of solutions to problems arising in the program. Over the last three years, representatives of management and labor have sought agreement for placing the system on a sound financial basis. The provision adopted by the committee reflects the agreement negotiated by representatives of railway management and labor (including benefit restructuring included in the House-passed omnibus reconciliation bill, H.R. 3982, June 26, 1981).

Present Law

Code sec. 3221 imposes on railroad employers a tax (Tier II tax) of 9.5 percent of compensation paid to the railroad employees in a calendar month, subject to a maximum limitation. Currently, the annual taxable compensation base is \$22,200; however, in no case does the tax apply to any amount paid in a month in excess of one-twelfth of the annual limitation (\$1,850 in 1981). The annual (and monthly) limitation on taxable compensation for the purposes of Code sec. 3221 is indexed pursuant to secs. 230 (c) and (d) of the Social Security Act. The rate of tax under sec. 3221 applies to employers only.

Explanation of Provision

The provision adopted by the committee will increase the rate of tax on railroad employers under section 3221 and will impose a new tax on railroad employees under section 3201.

The rate of tax on railroad employers will be increased from 9.5 to 11.75 percent of taxable compensation. In addition, there will be imposed a tax, in addition to other taxes under the Railroad Retirement Tax Act, of 2.0 percent on the taxable compensation of railroad employees. For the purposes of both the railroad employer and employee taxes, taxable compensation will be that amount of compensation determined under sections 230(c) and (d) of the Social Security Act.

Effective Date

This provision is effective with respect to compensation paid for services rendered after September 30, 1981.

Revenue Effect

It is estimated that this provision will increase budget receipts by \$512 million in fiscal year 1982, \$555 million in 1983, \$604 million in 1984, \$657 million in 1985, and \$712 million in 1986.

2. Advance transfers to the railroad retirement account

Present Law

Since 1946, the railroad retirement system and the social security programs have been coordinated. Presently, the two systems are coordinated through a complex financial interchange, linking benefits and taxes under the OASDHI programs with the tier-I railroad benefit component. The purpose of the financial interchange, created by legislation in 1951, is to place the social security trust funds in the same position they would have been if railroad employment had been covered under social security since its inception.

Generally, under the interchange, for a given fiscal year there is computed the amount of social security taxes that would have been collected if railroad employment had been covered directly by social security. This amount is netted against the amount of benefits social security would have paid to railroad beneficiaries based on railroad and nonrailroad earnings during that period. Where social security benefits that would have been paid exceed social security taxes that would have been due, the excess, plus an allowance for interest and administrative expenses, is transferred from the social security trust funds to the Railroad Retirement Account. That transfer is currently estimated to be approximately \$1.6 billion for fiscal year 1981. The determination of the amount to be transferred through the financial interchange for a given fiscal year is made in June of the year following the close of the preceding fiscal year. There is no authority in current law that would enable the Railroad Retirement Account to receive transfers of any other funds from the general fund of the Treasury. Revenues to the system are limited under present law to automatically appropriated receipts from railroad retirement taxes, a Federal Government contribution for certain "windfall benefits", and interest earned on invested reserves.

Explanation of Provision

In order to make available to the Railroad Retirement Account funds from the forthcoming financial interchange in the event of inadequate reserves in months prior to the transfer, the provision establishes limited authority in the Railroad Retirement Board to request from the Secretary of the Treasury and receive from the general fund such amounts as the Board may find necessary to maintain a balance in the Account sufficient to pay annuity amounts payable during the following month. Although the provision is an amendment to section 15 of the Railroad Retirement Act, 45 U.S.C. sec. 228, it is the view of the committee that the provision applies to transfers of revenues into the Railroad Retirement Account which are within its jurisdiction. The total amount of monies outstanding in the Account from

the general fund at any time during any fiscal year could not exceed the total amount of monies the Board and the trustees of the social security system estimate would be transferred under the financial interchange for such fiscal year. The rate of interest paid on amounts outstanding for any month would equal the average investment yield for the most recent auction of Treasury bills with maturities of 52 weeks.

Effective Date

This provision is effective upon enactment.

Revenue Effect

This provision will have no effect on unified budget receipts or outlays, although it might result in intrabudgetary transfers in some circumstances.

97TH CONGRESS }
1st Session }

SENATE

{ REPORT
No. 97-144

ECONOMIC RECOVERY TAX ACT OF 1981

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

H.J. Res. 266

together with

ADDITIONAL AND MINORITY VIEWS



JULY 6, 1981.—Ordered to be printed

Filed under authority of the order of the Senate of June 25 (legislative
day, June 1), 1981

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1981

No material amending the Social Security Act in this report.

ECONOMIC RECOVERY TAX ACT OF 1981

AUGUST 1, 1981.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4242]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4242) to amend the Internal Revenue Code of 1954 to encourage economic growth through reductions in individual income tax rates, the expensing of depreciable property, incentives for small businesses, and incentives for savings, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. *SHORT TITLE; TABLE OF CONTENTS; AMENDMENT OF 1954 CODE.*

(a) *SHORT TITLE.*—This Act may be cited as the “Economic Recovery Tax Act of 1981”.

(b) *TABLE OF CONTENTS.*—

Sec. 1. *Short title; table of contents; amendment of 1954 Code.*

TITLE I—INDIVIDUAL INCOME TAX PROVISIONS

Subtitle A—Tax Reductions

Sec. 101. *Rate cuts; rate reduction credit.*

Sec. 102. *20-percent maximum rate on net capital gain for portion of 1981, decrease in holding period.*

Sec. 103. *Deduction for two-earner married couples.*

Sec. 104. *Adjustment to prevent inflation-caused tax increase.*

2. Deduction for two-earner married couples

House bill.—Under present law, married taxpayers generally are treated as a single taxpaying unit. If married taxpayers elect to file separate rather than joint returns, they usually pay a higher tax. The differing rate schedules for single and married taxpayers give rise to a marriage penalty when two single wage earners of relatively equal income marry each other.

The House bill allows couples filing a joint return a deduction in computing adjusted gross income equal to a percentage of the lower earning spouse's qualified earned income (up to \$30,000 of income). In 1982, the percentage will be 5 percent (up to a \$1,500 maximum deduction) and in 1983 and subsequent years the percentage will be 10 percent (up to a \$3,000 maximum deduction).

Senate amendment.—Same as House bill.

Conference agreement.—The conference agreement is the same as the House bill and the Senate amendment.

3. Indexing

House bill.—Under present law, the individual income tax is based on various fixed amounts including the amounts that define the tax brackets, the zero bracket amount, and the personal exemption. These amounts are set by statute and are not adjusted for inflation.

Under the House bill, the income tax brackets, zero bracket amount, and personal exemption are adjusted for inflation (as measured by the Consumer Price Index), starting in 1985.

Senate amendment.—Same as House bill.

Conference agreement.—The conference agreement is the same as the House bill and the Senate amendment.

4. Individuals eligible for earned income credit

House bill.—No provision.

Senate amendment.—Under present law, individuals eligible for the earned income credit include all married individuals entitled to a dependency exemption for a child, surviving spouses, and heads of households who maintain a household for a child. In each case, the child must reside with the taxpayer in the United States.

Under the Senate amendment, an individual would not be eligible for the credit unless he or she is a citizen of the United States or an alien admitted as a permanent resident.

Conference agreement.—The conference agreement follows the House bill.

5. Child and dependent care credit

House bill.—No provision.

Senate amendment.—Under present law, there is a tax credit for 20 percent of expenditures for the care of children and other dependents incurred in connection with the taxpayer's employment, up to a maximum of \$2,000 of expenditures for each of the taxpayer's first two dependents.

The Senate amendment provides a refundable child care credit equal to 30 percent of employment-related expenses of taxpayers with incomes of \$10,000 or less. The credit will be reduced by one percent for each \$2,000, or fraction thereof, of income above \$10,000. For taxpayers with adjusted gross income above \$28,000,

the credit rate will be 20 percent. The maximum amount of employment-related expenses taken into account will be increased to \$2,400 (one dependent) and \$4,800 (two or more dependents). Expenditures for out-of-home, noninstitutional care of a disabled spouse or dependent are made eligible for the credit. Expenditures for services provided by a dependent care center not in compliance with State or local regulations will not be eligible for the credit.

The Senate amendment also provides that child care provided by an employer under a written nondiscriminatory plan will not be included in an employee's gross income. In addition, employers will be entitled to a credit equal to 50 percent of the cost of any employer-provided child and dependent care.

Conference agreement.—The conference agreement follows the Senate amendment with several modifications. Under the conference agreement, the increased child care credit will not be refundable. In addition, employers will not be entitled to a tax credit for employer-provided child and dependent care.

In general, the provision is effective in taxable years beginning after December 31, 1981. The phase-down of the credit percentage applies to remuneration paid after December 31, 1981.

6. Charitable contributions deduction for nonitemizers

House bill.—Under present law, charitable contributions may be deducted from adjusted gross income in determining taxable income. Thus, in order for an individual taxpayer to deduct charitable contributions, the taxpayer must itemize deductions. Present law also provides that charitable contributions are allowable as deductions only if verified under Treasury regulations.

The House bill allows all taxpayers to deduct allowable charitable contributions whether or not they itemize deductions.

The deduction would be a percentage of contributions up to a fixed dollar amount of contributions as follows:

Year	Percentage	Cap
1982	25	\$100
1983	25	100
1984	25	100
1985	50	.....
1986	100	.....
1987	Provisions expires.	.....

Senate amendment.—The Senate amendment is similar to the House bill with the following limitations:

Year	Percentage	Cap
1982	25	\$100
1983	25	100
1984	25	.....
1985	50	.....
1986	100	.....
1987	Provision expires.	.....

Conference agreement.—The conference agreement generally follows the Senate amendment with the addition of a \$300 contribution cap in 1984 (\$75 maximum deduction). In addition, the confer-

76. Cash management: Corporate estimated tax payments

House bill.—Under present law, corporations whose taxable income exceeded \$1 million in any of the three preceding taxable years must pay estimated tax of at least 60 percent of current year's tax liability regardless of their prior year's tax liability. The House bill provides that corporations whose taxable income exceeded \$1 million in any of three preceding taxable years will be required to pay estimated tax of at least 80 percent of current year's tax liability regardless of their prior year's tax liability. The provision is effective for taxable years beginning after December 31, 1981.

Senate amendment.—The Senate amendment is similar to the House bill, except that the 80 percent requirement is phased in over a three-year period. In 1982, large corporations will have to be at least 65 percent current with estimated tax payments. This will increase to 75 percent in 1983, and to 80 percent for 1984 and subsequent years. The provision is effective for taxable years beginning after December 31, 1981.

Conference agreement.—The conference agreement follows the Senate amendment.

77. Declaration and payment of estimated taxes by individuals

House bill.—In general, present law provides that individuals whose tax liability, over amounts withheld during the year, is less than \$100 are not required to file declarations of estimated taxes. The House bill increases the tax liability threshold for the payment of estimated taxes from \$100 to \$500 over a four year period, as follows:

Taxable years beginning in:	Threshold amount
1982	\$200
1983	300
1984	400
1985 and thereafter	500

Individuals whose tax liability, in excess of withholding does not exceed the threshold amount would not be required to declare or pay estimated tax, nor would they be penalized for underpayment of estimated tax.

The increase in the tax liability threshold begins in taxable years beginning after December 31, 1981.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

78. Railroad retirement taxes

House bill.—The House bill has the following provisions:

Tier II taxes.—Under present law (code section 3221), there is imposed on railroad employers a tax of 9.5 percent of compensation paid in a calendar month, subject to a maximum limitation. Currently, the annual taxable compensation base is \$22,200; however, in no case does the tax apply to any amount paid in a month in excess of one-twelfth of the annual limitation (\$1,850 in 1991). The annual (and monthly) limitation on taxable compensation for the purposes of section 3221 is indexed pursuant to section 230 (c) and (d) of the Social Security Act. The rate of tax under section 3221 applies to employers only.

The House bill will, pursuant to a negotiated agreement between railway management and labor, provide for adjustments in the financing of the tier-II pension component. The tax on employers under section 3221 will be increased from 9.5 to 11.75 percent, an increase of 2.25 points. In addition, the provision will provide for a new tax of 2 percent on the compensation of employees (as defined in section 3221).

Advance transfers to the railroad retirement account.—Generally, under the railroad retirement and social security interchange, for a given fiscal year there is computed the amount of social security taxes that would have been collected if railroad employment had been covered directly by social security. This amount is netted against the amount of benefits social security would have paid to railroad beneficiaries based on railroad and nonrailroad earnings during that period. Where social security benefits that would have been paid exceed social security taxes that would have been due, the excess, plus an allowance for interest and administrative expenses, is transferred from the social security trust funds to the Railroad Retirement Account. The financial interchange amount for a given fiscal year is determined and transferred no later than June of the year following the close of the preceding fiscal year.

The House bill provides advanced, limited transfers to the Railroad Retirement Account from the general fund in amounts necessary to make monthly benefit payments. In no case will the amounts outstanding at any time for any fiscal year under this authority exceed the estimated interchange transfer for that fiscal year. The Board will pay the prevailing rate of interest currently being paid on short-term instruments of the Department of the Treasury on amounts transferred under this authority. The borrowing authority will be effective upon enactment.

Payments of employee taxes by railroad employers.—Under present law (code section 3221(e)(1)(iii)), payments made by railroad employers of railroad employee taxes under section 3211 without deduction from the remuneration of the employee are excluded from the definition of compensation for the purposes of the Railroad Retirement Tax Act (RRTA). Until 1981, a similar provision was included in the Federal Insurance Contributions Act (code section 3121(a)(6) and section 209(f) of the Social Security Act). The exclusion of such payment from the definition of wages for FICA tax and social security benefit computation purposes was eliminated by section 1141(a)(1) of Public Law 96-499, the Omnibus Reconciliation Act of 1980.

The House bill provides that payments by an employer of employee railroad payroll taxes, without deduction from the employee's remuneration, will be included in taxable compensation for RRTA purposes. This change will conform the provisions of the Railroad Retirement Tax Act to the corresponding provisions of the recently amended Federal Insurance Contributions Act. The changes made by this provision will be effective with respect to compensation paid for services rendered after September 30, 1981.

Definition of compensation.—Under present law, there is imposed on employers a tax on so much of compensation paid in any calendar month by such employer for services rendered by an employee. It is unclear whether the intent of the law is to tax compensation when paid or when earned.

The House bill provides that compensation that is paid in one calendar month but that would be payable in a prior or subsequent taxable month but for the fact that the prescribed date of payment would fall on a Saturday, Sunday, or legal holiday will be deemed to have been paid in such prior or subsequent taxable month. The bill thus makes clear the treatment for RRTA purposes of compensation "bunched" in any month for services rendered in the preceding month.

The House bill also provides that, in the absence of evidence to the contrary (e.g., the statutory presumption curing "bunching" of compensation problems in certain months, as clarified by the immediately preceding provision), payments by railroad employers shall be presumed to be compensation for services rendered as an employee in the period for which the payment is made, an employee receiving retroactive wage payments (such as lump sum retroactive wage payments and crew consists payments) will be deemed under the provision to be compensation paid in the period for which the payment is made unless the employee requests in writing (pursuant to existing provisions in sec. 3231(e)(2)) that such compensation was earned in a period other than the period in which it was paid.

This provision generally applies to taxable years ending on or after the date of enactment. It also applies in taxable years ending before enactment for which the period for assessment, collection, or claim for credit or refund of taxes has not expired.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill with several modifications. The conference agreement does not include the House bill provision dealing with advance transfers to the railroad retirement account. Under the conference agreement, the provision that clarifies the definition of compensation is effective for taxable years beginning after December 31, 1981. It is the specific intent of the conferees that no inference be drawn from this clarification for taxable years beginning after 1981 as to Congressional intent with respect to prior legislation concerning the definition of compensation for the purposes of administrative or judicial proceedings.

ECONOMIC RECOVERY TAX ACT OF 1981

AUGUST 1 (legislative day, JULY 8), 1981.—Ordered to be printed

Mr. DOLE, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4242]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4242) to amend the Internal Revenue Code of 1954 to encourage economic growth through reductions in individual income tax rates, the expensing of depreciable property, incentives for small businesses, and incentives for savings, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; AMENDMENT OF 1954 CODE.

(a) *SHORT TITLE.*—This Act may be cited as the “Economic Recovery Tax Act of 1981”.

(b) *TABLE OF CONTENTS.*—

Sec. 1. Short title; table of contents; amendment of 1954 Code.

TITLE I—INDIVIDUAL INCOME TAX PROVISIONS

Subtitle A—Tax Reductions

Sec. 101. Rate cuts; rate reduction credit.

Sec. 102. 20-percent maximum rate on net capital gain for portion of 1981, decrease in holding period.

Sec. 103. Deduction for two-earner married couples.

Sec. 104. Adjustment to prevent inflation-caused tax increase.

This Senate Conference Report is identical to House Conference Report 97-215.

Finder's Aid
P.L. 97-35 (95 Stat. 357) Approved August 13, 1981
"Omnibus Budget Reconciliation Act of 1981"

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep.* 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Repeal of Obsolete Authority for Medical Assistance	Title I	2184(a)(1)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	1	2184(a)(2)(A)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	1	2184(a)(2)(B)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	1	2184(a)(2)(C)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2	2184(a)(3)(A)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2(a)	2184(a)(3)(B)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2(a)(10)	2184(a)(3)(C)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2(a)(11) Stricken	2184(a)(3)(D)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2(a)(12) Stricken	2184(a)(3)(D)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	2(a)(13) Stricken	2184(a)(3)(D)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	3(a)(1) Stricken	2184(a)(4)(A)	816	336, 365	--	--	--

*No material relating to the Social Security Act in Vol. I.

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Repeal of Obsolete Authority for Medical Assistance	3(a)(2)	2184(a)(4)(B)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	3(a)(3) Stricken	2184(a)(4)(A)	816	336, 365	--	--	--
Conforming Amendment-- Elimination of Self- Care Attainment Services	3(a)(4)	2353(a)(1)(A)	871	--	--	572	--
Conforming Amendment-- Elimination of Self- Care Attainment Services	3(a)(5) Stricken	2353(a)(1)(B)	871	--	--	573	--
Conforming Amendment-- Elimination of Self- Care Attainment Services	3(c) Repealed	2353(a)(2)	872	--	--	574	--
Repeal of Obsolete Authority for Medical Assistance	3(d) Stricken	2184(a)(4)(C)	816	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	6(b) Stricken	2184(a)(5)	817	336, 365	--	--	--
Repeal of Obsolete Authority for Medical Assistance	6(c) Stricken	2184(a)(5)	817	336, 365	--	--	--
Old-Age--Payment for First Full Month of Eligibility	202(a)(end) New (A) and (B)	2203(a)	835	--	254, 290	--	975
Wife's Insurance Benefits--Payment for First Full Month of Eligibility	202(b)(1)(end) New (i) and (ii)	2203(b)(1)	835	--	254, 290	--	975
Husband's Insurance Benefits--Payment for First Full Month of Eligibility	202(c)(1)(end) New (i) and (ii)	2203(c)(1)	836	--	254, 290	--	975

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(1)(B)	2210(a)(1)	841	--	251, 283	427, 450, 537, 544, 575	978
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(1)(B)(1)	2210(a)(5)(A)	841	--	--	427, 450, 575	978
Child's Insurance Benefits--Payment for First Full Month of Eligibility	202(d)(1)(mid) New (i) and (ii)	2203(d)(1)	836	--	254, 290	--	975
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(1)(E)(ii)	2210(a)(1)	841	--	251, 283	427, 450, 576	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(1)(F)(i)	2210(a)(1)	841	--	251, 283	427, 450, 576	978
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(1)(F)(ii)	2210(a)(5)(A)	841	--	--	427, 450, 576	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(1)(G)(III)	2210(a)(1)	841	--	251, 283	427, 450, 576	978
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(1)(G)(IV)	2210(a)(5)(A)	841	--	--	427, 450, 576	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits and Establishes Age 19 Limitations	202(d)(6)(A)	2210(a)(5)(B)	841	--	251, 283	427, 450, 577	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(6)(D)(i)	2210(a)(1)	841	--	251, 283	427, 450, 578	978
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(6)(D)(ii)	2210(a)(5)(A)	841	--	--	427, 450, 578	978

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(6)(E)(i)	2210(a)(1)	841	--	251, 283	427, 450, 578	978
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(6)(E)(ii)	2210(a)(5)(A)	841	--	--	427, 450, 578	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(7)(A)	2210(a)(1)	841	--	251, 283	427, 450, 578	978
Child's Insurance Benefits--Elimination of Postsecondary Schools (Technical Amendment)	202(d)(7)(A)	2210(a)(2)(A)	841	--	251, 283	427, 450, 578	--
Child's Insurance Benefits--Elimination of Postsecondary Schools (Technical Amendment)	202(d)(7)(A)	2210(a)(2)(B)	841	--	251, 283	427, 450, 578	--
Child's Insurance Benefits--Student Status Deemed Throughout a Month	202(d)(7)(A)(end)	2203(d)(2)	836	--	254, 290	--	--
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(7)(B)	2210(a)(1)	841	--	251, 283	427, 450, 578	978
Child's Insurance Benefits--Elimination of Postsecondary Schools (Technical Amendment)	202(d)(7)(B)	2210(a)(2)(A)	841	--	251, 283	578	--
Child's Insurance Benefits--Definition of "Elementary or Secondary School"	202(d)(7)(C)	2210(a)(3)	841	--	251, 283	579	--
Child's Insurance Benefits--Maximum Age for Students--19	202(d)(7)(D)	2210(a)(5)(A)	841	--	--	427, 450, 579	978
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits	202(d)(7)(D)	2210(a)(1)	841	--	251, 283	427, 450, 579	978

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Child's Insurance Benefits--Elimination of Postsecondary Student Benefits (Technical Amendment)	202(d)(7)(D)	2210(a)(4)	841	--	251, 283	579	--
Child's Insurance Benefits--Elimination of Postsecondary Schools (Technical Amendment)	202(d)(7)(D)	2210(a)(2)(A)	841	--	251, 283	579	--
Lump-Sum Death Benefits-- Disregards Repeal of Minimum Benefit Provisions	202(i)	2201(f)	833	--	--	581	--
Lump-Sum Death Benefits-- Elimination of Reimburse- ment for Burial Expenses	202(i)(1) Stricken	2202(a)(1)(A)	834	--	254, 289	428, 453, 538, 545, 581	974
Lump-Sum Death Benefits-- Payment in Lieu of Widow or Widower Living in the Same Household	202(i)(1) New	2202(a)(1)(A)	834	--	254, 289,	428, 454, 581	974
Lump-Sum Death Benefits-- Elimination of Reimburse- ment for Burial Expenses	202(i)(2) Stricken	2202(a)(1)(A)	834	--	254, 289	428, 453, 581	974
Lump-Sum Death Benefits-- Payment Divided Among Children Eligible for Child's Benefits	202(i)(2) New	2202(a)(1)(A)	834	--	254, 289	428, 454, 582	974
Lump-Sum Death Benefits-- Elimination of Reimburse- ment for Burial Expenses	202(i)(3) Stricken	2202(a)(1)(A)	834	--	254, 289	428, 453, 581	974
Lump-Sum Death Benefits-- Elimination of Reimburse- ment for Burial Expenses	202(i)(4) Stricken	2202(a)(1)(A)	834	--	254, 289	428, 453, 581	974
Lump-Sum Death Benefits-- Elimination of Reimburse- ment for Burial Expenses (Technical Amendment)	202(i)	2202(a)(1)(B)	835	--	254, 289	581	--
Survivor's Benefit-- Repeal of Minimum Amount	202(m) Repealed	2201(b)(10)	831	--	252, 285	427, 451, 582, 538	974

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Reduction of Benefit Amounts--Repeal of Minimum Amounts--Lowering of Primary Insurance Amounts (Technical Amendment)	202(q)(4)	2201(d)(1)	832	--	252, 285	586	--
Reduction of Benefits-- Before Rounding of Primary Insurance Amount	202(q)(8)	2206(b)(1)(A)	838	--	253, 286	588	976
Reduction of Certain Benefits--Rounded to Higher Multiples of \$0.10	2202(q)(8)	2206(b)(1)(B)	838	--	253, 286	--	976
Reduction of Benefits-- Repeal of Minimum Benefit Amount (Technical Amendment)	202(q)(10)	2201(d)(2)	832	--	252, 285	588	--
Mother's or Father's Benefits--Termination at Child's Attainment of Age 16 (Technical Amendment)	202(s)	2205(a)(2)	837	--	252, 284	--	--
Mother's or Father's Benefits--Termination at Child's Attainment of Age 16	202(s)(1)	2205(a)(1)	837	--	252, 284	--	975
Primary Insurance Amount-- Repeal of Minimum Benefit (Technical Amendment)	202(w)(1)	2201(b)(11)	831	--	252, 285	589	--
Primary Insurance Amount-- Repeal of Minimum Benefit (Technical Amendment)	202(w)(5)	2201(b)(11)	831	--	252, 285	589	--
Family Maximum--Rounding to Next Lower Multiple of \$0.10	203(a)(1)	2206(b)(2)	838	--	253, 286	--	976
Family Maximum--Rounding to Next Lower Multiple of \$0.10	203(a)(3)(B)(iii)	2206(b)(3)	838	--	253, 286	--	976
Family Maximum--Repeal of Minimum Benefit (Technical Amendment)	203(a)(8)	2201(c)(6)	831	--	252, 285	594	--
Family Maximum--Rounding to Next Lower Multiple of \$0.10	203(a)(8)(end)	2206(b)(4)	838	--	253, 286	--	976

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Computations--Rounding to Next Lower Multiple of \$0.10	215(a)(1)(A)	2206(b)(5)	838	--	253, 286	539	976
Computations--Repeal of Minimum Benefit	215(a)(1)(C)(i)	2201(a)	830	--	252, 285	427, 451, 538, 544, 595	--
Computations--Repeal of Minimum Benefit (Technical Amendment)	215(a)(1)(C)(ii)	2201(b)(1)	830	--	252, 285	595	--
Computations--Repeal of Minimum Benefit (Technical Amendment)	215(a)(3)(A)	2201(b)(2)	830	--	252, 285	597	--
Computations--Repeal of Minimum Benefit (Technical Amendment)	215(a)(4)	2201(b)(3)(A)	830	--	252, 285	597	--
Computations--Repeal of Minimum Benefit	215(a)(4)	2201(c)(2)	831	--	252, 285	427, 451, 597	974
Computations--Repeal of Minimum Benefit	215(a)(4)(I)	2201(b)(3)(B)	830	--	252, 285	427, 451, 597	974
Computations--Repeal of Minimum Benefit	215(a)(5)	2201(c)(3)(A)	831	--	252, 285	427, 451, 598	974
Computations--Repeal of Minimum Benefit	215(a)(5)	2201(c)(3)(B)	831	--	252, 285	427, 451, 598	974
Computations--Repeal of Minimum Benefit	215(a)(6) New	2201(c)(1)	831	--	252, 285	427, 451, 598	974
Recomputations--Repeal of Minimum Benefit	215(f)(7)	2201(c)(4)	831	--	252, 285	427, 451, 599	974
Recomputations--Repeal of Minimum Benefit (Technical Amendment)	215(f)(8)	2201(b)(4)	831	--	252, 285	599	--
Computations--Rounding to Next Lower Multiple of \$1.00	215(g)	2206(a)	838	--	253, 286	429, 458, 600	976

<u>Subject</u>	<u>S. S. Act Section</u>	<u>P. L. Section</u>	<u>95 Stat.</u>	<u>H. Rep. 97-158 Vol. II</u>	<u>H. Rep. 97-158 Vol. III</u>	<u>S. Rep. 97-139</u>	<u>H. Con. 97-208</u>
Cost-of-Living Increases-- Repeal of Minimum Benefit (Technical Amendment)	215(i)(2)(A)(ii)	2201(b)(6)	831	--	252, 285	601	--
Cost-of-Living Increases --Rounding to Next Lower Multiple of \$0.10	215(i)(2)(A)(ii)	2206(b)(6)	838	--	252, 285	--	976
Cost-of-Living Increases --Repeal of Minimum Benefit (Technical Amendment)	215(i)(2)(A)(ii) (II)	2201(b)(5)	831	--	252, 285	600	--
Cost-of-Living Increases --Repeal of Minimum Benefit (Technical Amendment)	215(i)(2)(A)(iii)	2201(b)(7)	831	--	252, 285	601	--
Cost-of-Living Increases --Repeal of Minimum Benefit	215(i)(2)(A)(iv) Stricken	2201(b)(8)	831	--	252, 285	427, 451, 601	974
Cost-of-Living Increases --Repeal of Minimum Benefit	215(i)(2)(A)(v) Stricken	2201(b)(8)	831	--	252, 285	427, 451, 602	974
Cost-of-Living Increases --Repeal of Minimum Benefit (Technical Amendment)	215(i)(2)(D)	2201(b)(9)	831	--	252, 285	603	--
Cost-of-Living Increases --Repeal of Minimum Benefit (Technical Amendment)	215(i)(4)	2201(c)(5)	831	--	252, 285	603	--
Cost-of-Living Increases --Rounding to Next Lower Multiple of \$0.10	215(i)(4)	2206(b)(7)	838	--	253, 286	--	976
Definition of Wife-- Conditions Deemed to Exist Throughout Month	216(b)(end)	2203(b)(2)	835	--	254, 290	--	--
Definition of Widow-- (Technical Amendment)	216(c)	2202(a)(2)(A)	835	--	--	--	--
Definition of Child-- Conditions Deemed to Exist Throughout Month	216(e)(end)	2203(d)(3)	836	--	254, 290	--	--

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Definition of Husband-- Conditions Deemed to Exist Throughout Month	216(f)	2203(c)(2)	836	--	254, 290	--	--
Definition of Widower-- (Technical Amendment)	216(g)	2202(a)(2)(B)	835	--	--	--	--
Paternity--Conditions Deemed to Exist Through- out Month	216(h)(3)(end)	2203(d)(4)	837	--	254, 290	--	--
Veterans Benefits--Repeal of Minimum Benefit	217(b)(1)	2201(c)(7)	832	--	252, 285	427, 451, 606	--
Rehabilitation Services-- Reimbursement for Success- ful Services	222(d)	2209(a)	840	--	254, 288	429, 457	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224	2208(a)(1)	839	--	--	428, 455, 538, 610	977
Reduction of Disability Benefits up to Age 65	224(a)	2208(a)(2)	839	--	--	428, 455, 610	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224(a)(2)	2208(a)(3)	839	--	--	428, 455, 610	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224(a)(4)	2208(a)(4)	839	--	--	428, 455, 610	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224(b)	2208(a)(5)	839	--	--	428, 455, 611	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224(d)	2208(a)(6)(A)	839	--	--	428, 455, 611	977
Laws or Plans Providing for Reduction Due to Receipt of Social Security Benefits	224(d)	2208(a)(6)(B)	839	--	--	456, 611	977
Reduction of Disability Benefits Due to Receipt of Other Benefits	224(e)	2208(a)(7)	839	--	--	428, 455, 611	977

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Reduction of Disability Benefits--Disclosure of Information to the Secretary	224(h) New	2208(a)(8)	839	--	--	456, 612	--
Entitlement to Hospital Insurance Benefits--Conditions Deemed to Exist Throughout Month (Technical Amendment)	226(a)(2)	2203(e)(1)	837	--	254, 290	--	--
Entitlement to Hospital Insurance Benefits--Conditions Deemed to Exist Throughout Month (Technical Amendment)	226(a)(2)	2203(e)(2)	837	--	254, 290	--	--
International Agreements--Repeal of Minimum Benefit (Technical Amendment)	233(c)(2)	2201(b)(12)	831	--	252, 285	613	--
Unemployment Compensation --Deduction for Child Support (Technical Amendment)	303(e)(1)	2335(b)(3)	864	--	260, 303	--	--
Unemployment Compensation --Deduction for Child Support	303(e)(2) New	2335(b)(1)	863	--	260, 303	--	986
Unemployment Compensation (Technical Amendment)	303(e)(2) Redesignated as (e)(3)	2335(b)(1)	863	--	--	--	--
Unemployment Compensation (Technical Amendment)	303(e)(3) Redesignated as (e)(4)	2335(b)(1)	863	--	--	--	--
Unemployment Compensation (Technical Amendment)	303(e)(3)	2335(b)(2)	864	--	--	--	--
AFDC--State Plans--Puerto Rico, Guam, Virgin Islands	402(a)(5) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--State Plans--Puerto Rico, Guam, Virgin Islands	402(a)(5)	2353(b)(2)	872	--	--	--	--
AFDC--State Plans--Income and Resources--House, Car, Food Stamps, Housing Subsidy	402(a)(7)	2302	844	--	259, 301	436, 503, 541, 614	979

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AFDC--State Plans-- Income and Resources-- Stepparent	402(a)(7)	2320(b)(1)	857	--	256, 293	437, 506	980
AFDC--State Plans-- Income and Resources-- Student	402(a)(8)	2301	843	--	259, 298	616	--
AFDC--State Plans-- Retrospective Budgeting	402(a)(13) New	2315(a)	855	--	257, 294	440, 516, 541, 618	982
AFDC--State Plans-- Puerto Rico, Guam, Virgin Islands	402(a)(13) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--State Plans-- Monthly Reporting	402(a)(14) New	2315(a)	855	--	257, 294	440, 516, 618	982
AFDC--State Plans-- Puerto Rico, Guam, Virgin Islands	402(a)(14) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--State Plans-- Puerto Rico, Guam, Virgin Islands	402(a)(15) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--State Plans-- Puerto Rico, Guam, Virgin Islands	402(a)(15)	2353(b)(2)	872	--	--	--	--
AFDC--State Plans-- Family Planning	402(a)(15)	2353(c)(1)	872	--	--	618	--
AFDC--State Plans-- Family Planning	402(a)(15)	2353(c)(2)	872	--	--	619	--
AFDC--State Plans-- Income (Lump-Sum Payments) New	402(a)(17)	2304	845	--	--	436, 505, 541, 619	979
AFDC--Income Limitation	402(a)(18) New	2303	845	--	256, 292	436, 504, 619	979
AFDC--Work Registration (Technical Amendment)	402(a)(19)(A) (end)	2313(b)(4)(A)	854	--	--	620	--
AFDC--Work Registration (Technical Amendment)	402(a)(19)(A) (end)	2313(b)(4)(B)	854	--	--	620	--

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AFDC--Work Registration (Technical Amendment)	402(a)(19)(A) (end)	2313(b)(4)(C)	854	--	--	620	--
AFDC--Work Registration (Technical Amendment)	402(a)(19)(A) (end)	2313(b)(4)(D)	854	--	--	620	--
AFDC--Work Registration-- School Attendance	402(a)(19)(A)(i)	2314(a)	854	--	--	440, 515, 619	982
AFDC--Work Registration-- Parent Care of Child	402(a)(19)(A)(v)	2313(b)(1)	854	--	--	440, 515, 620	982
AFDC--Work Registration-- Parent or Relative Care of Child	402(a)(19)(A)(v)	2314(b)	854	--	--	440, 515, 620	--
AFDC--Work Registration-- Caretaker of Child	402(a)(19)(A)(vi)	2313(b)(2)	854	--	--	440, 515, 620	--
AFDC--Work Registration (Technical Amendment)	402(a)(19)(A)(v1)	2313(b)(3)(A)	854	--	--	620	--
AFDC--Work Registration (Technical Amendment)	402(a)(19)(A)(vii)	2313(b)(3)(B)	854	--	--	620	--
AFDC--Work Registration-- Parent Care of Child	402(a)(19)(A) (viii) New	2313(b)(3)(C)	854	--	--	440, 515, 620	982
AFDC--Work Incentive-- Refusal by Principal Earner	402(a)(19)(F)(ii) New	2313(c)(1)	854	--	--	439, 515, 621	982
AFDC--Work Incentive (Technical Amendment)	402(a)(19)(F)(ii) Redesignated as (iii)	2313(c)(1)	854	--	--	621	--
AFDC--Work Incentive (Technical Amendment)	402(a)(19)(F)(iii) Redesignated as (iv)	2313(c)(1)	854	--	--	621	--
AFDC--Work Incentive (Technical Amendment)	402(a)(19)(F)(iv) Redesignated as (v)	2313(c)(1)	854	--	--	621	--
AFDC--Participation in a Strike	402(a)(21) New	2310	852	--	--	439, 512, 622	981

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AFDC--Adjustment for Incorrect Payments	402(a)(22) New	2318	856	--	258, 298	441, 519, 622	983
AFDC--State Plan (Technical Amendment)	402(a)(29)	2306(a)(1)	846	--	--	624	--
AFDC--State Plan (Technical Amendment)	402(a)(30)	2306(a)(2)	846	--	--	624	--
AFDC--State Plan (Technical Amendment)	402(a)(30)	2316(1)	856	--	--	624	--
AFDC--Income of Stepparents	402(a)(31) New	2306(a)(3)	846	--	256, 293	437, 506, 624	980
AFDC--State Plan (Technical Amendment)	402(a)(31)	2316(2)	856	--	--	625	--
AFDC--State Plan (Technical Amendment)	402(a)(31)	2320(a)(1)	857	--	--	625	--
AFDC--No Payment of Less Than \$10.00	402(a)(32) New	2316(3)	856	--	--	440, 517, 625	983
AFDC--State Plan (Technical Amendment)	402(a)(32)	2320(a)(2)	857	--	--	--	--
AFDC--Reduced Matching of Training Costs	402(a)(33) New	2320(a)(3)	857	--	--	441, 520	983
AFDC--Treatment of Earned Income Advance Amount	402(d)(1)	2305	845	--	--	436, 505, 625	979
AFDC--Retrospective Budgeting Based on Months Other Than Prescribed	403(a)(end)	2315(b)	855	--	257, 294	628	--
AFDC--Payment to States-- Removal of Limit on Restricted Payments	403(a)	2317(a)	856	--	--	628	983
AFDC--Repeal of Obsolete Authority for Medical Assistance	403(a)(1)	2184(b)(1)(A)	817	336, 365	--	--	--

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AFDC--Repeal of Obsolete Authority for Medical Assistance (Technical Amendment)	403(a)(1)(A)	2184(b)(1)(B)	817	336, 365	--	--	--
AFDC--Repeal of Obsolete Authority for Medical Assistance	403(a)(2)	2184(b)(1)(C)	817	336, 365	--	--	--
AFDC--Payment to States-- Community Work Experience	403(a)(3)	2307(b)	848	--	--	628	980
AFDC--Payment to States-- Puerto Rico, Guam, Virgin Islands	403(a)(3) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--Payment to States-- Puerto Rico, Guam, Virgin Islands	403(a)(3)	2353(b)(2)	872	--	--	--	--
AFDC--Payment to States-- Training Costs	403(a)(3)(A) Repealed	2319(a)	857	--	--	441, 520, 627	983
AFDC--Payment to States-- Training Costs in Puerto Rico, Guam, Virgin Islands	403(a)(3)(A) (iii) note Repealed	2319(b)	857	--	--	--	--
AFDC--Payment to States-- Conforming Amendment-- Title XX	403(a)(3)	2353(d)	872	--	---	628	--
AFDC--Payment to States-- Training Costs	403(d)(1)	2319(c)	857	--	--	441, 520	983
AFDC--Payment to States-- Family Planning--Puerto Rico, Guam, Virgin Islands	403(e) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--Child Health Screening (Penalties Against States) (EPSDT)*	403(g) Repealed	2181(a)(1)	815	280, 302, 363	--	--	965
AFDC--Definition of Dependent Child (Student)	406(a)(2)	2311	852	--	259, 298	439, 513, 629	982

* EPSDT - Early and Periodic Screening Diagnostic and Treatment Services

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AFDC--Repeal of Obsolete Authority for Medical Assistance	406(b)	2184(b)(2)(A)	817	336, 365	--	--	--
AFDC--Definitions-- Dependent Child-- Pregnant Women	406(b)	2312(a)	853	--	--	439, 514, 629	982
AFDC--Waiver of Restricted Payment Provisions	406(b)	2317(b)	856	--	--	440, 518, 630	983
AFDC--Family Services-- Puerto Rico, Guam, Virgin Islands	406(d) note Repealed	2353(b)(1)	872	--	--	--	--
AFDC--Emergency Assis- tance--Medical Assistance Not Covered by Title XIX	406(e)(1)(A)	2184(b)(2)(B)	817	--	--	--	--
AFDC--Definitions-- Limitations on Pregnant Women	406(g) New	2312(b)	853	--	--	439, 514, 630	982
AFDC--Dependent Children of Unemployed Parents	407	2313(a)(1)	853	--	258, 297	439, 631	982
AFDC--Parent--Principal Earner	407(a)	2313(a)(2)	853	--	258, 297	439, 515, 631	982
AFDC--Parent--Principal Earner	407(b)(1)(A)	2313(a)(3)(A)	853	--	258, 297	439, 515, 631	982
AFDC--Dependent Children of Unemployed Parents	407(b)(1)(B)	2313(a)(3)(B)	853	--	258, 297	439, 515, 631	982
AFDC--Dependent Children of Unemployed Parents	407(b)(2)(A)	2313(a)(4)(A)	853	--	258, 297	439, 515, 631	982
AFDC--Parent--Principal Earner	407(b)(2)(C)(i)	2313(a)(4)(B)	853	--	258, 297	439, 515, 632	982
AFDC--Current Registra- tions for Work Incentive Program	407(b)(2)(C)(1)	2313(c)(2)	854	--	--	632	982

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AFDC--Parent--Principal Earner	407(b)(2)(C)(11)	2313(a)(4)(B)	853	--	258, 297	439, 515, 632	982
AFDC--Parent--Principal Earner	407(b)(2)(D)	2313(a)(4)(B)	853	--	258, 297	439, 515, 632	982
AFDC--Parent--Principal Earner	407(c)	2313(a)(5)	853	--	258, 297	439, 515, 632	982
AFDC--Community Work Experience Program	407(d)(1)	2353(q)	874	--	257, 295	437, 508	980
AFDC--Dependent Children of Unemployed Parents (Technical Amendment)	407(d)(2)	2313(a)(6)(A)	853	--	--	633	--
AFDC--Dependent Children of Unemployed Parents (Technical Amendment)	407(d)(3)	2313(a)(6)(B)	854	--	--	633	--
AFDC--Definitions of Principal Earner	407(d)(4) New	2313(a)(6)(C)	854	--	258, 297	439, 515, 633	982
AFDC--Dependent Children of Unemployed Parents (Technical Amendment)	407(e)	2313(a)(7)	854	--	258, 297	633	--
AFDC--Establishment of Community Work Experience Programs	409	2307(a)	846	--	257, 295	437, 508, 637	--
AFDC--Income of Step-parents Living With Dependent Child	412(b)	2306(b)	846	--	256, 293	437, 506, 639	980
AFDC--Establishment of Work Supplementation Program	414 New	2308	848	--	257, 295	438, 510, 639	980
AFDC--Alien's Sponsor's Income	415 New	2320(b)(2)	857	--	259, 299	--	984
AFDC--Work Incentive Demonstration Program	445 New	2309	850	--	--	438, 512, 647	981
Child Support--Support for Spousal Custodian	451	2332(a)	861	--	259, 301	441, 522, 649	986

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Child Support--Support for Spousal Custodian	452(a)(1)	2332(b)(1)(A)	861	--	259, 301	441, 522, 649	986
Child Support--Support for Spousal Custodian	452(a)(7)	2332(b)(1)(B)	861	--	259, 301	441, 522, 649	986
Child Support--Reporting of Number of Cases of Spousal Support	452(a)(10)(C)	2332(b)(1)(C)	861	--	--	650	--
Child Support--Collection --Spousal Support	452(b)	2332(b)(2)(A)	861	--	259, 301	441, 522, 651	986
Child Support--Court or Administrative Order	452(b)	2332(b)(2)(B)	861	--	--	651	986
Child Support--Reimburse- ment of Costs of the Secretary of Treasury by State (Technical Amendment)	452(b)	2332(b)(2)(C)	861	--	--	--	--
Child Support--Crediting of Reimbursement by States to Appropriation Accounts	452(b)	2332(b)(2)(D)	861	--	--	--	--
Child Support--Cost of Collection--Exclusion of Issues and Fees	453(a)	2333(c)	863	--	--	--	--
Child Support--Support of Spousal Custodian	453(c)(1)	2332(c)	862	--	259, 301	652	986
Child Support--State Plan for Child and Spousal Support	454	2332(d)(1)	862	--	259, 301	652	--
Child Support--State Plan for Child and Spousal Support	454	2332(d)(2)	862	--	259, 301	652	--
Child Support--Enforcement of Parent Support Obligation for Spouse in Custody of Child	454(4)(B)	2332(d)(3)	862	--	259, 301	652	986
Child Support--Support of Spousal Custodian (Technical Amendment)	454(5)	2332(d)(4)	862	--	259, 301	653	--

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Child Support--Services to Ineligible Individuals Upon Application and Payment of Fee	454(6)(B)	2333(a)(1)	862	--	260, 302	653	986
Child Support--Fee Retentions by a State	454(6)(C)	2333(a)(2)	862	--	260, 302	442, 522, 653	986
Child Support--Support of Parent Custodian	454(9)(C)	2332(d)(5)	862	--	259, 301	441, 522, 653	986
Child Support--Support of Parent Custodian (Technical Amendment)	454(11)	2332(d)(6)	862	--	--	654	--
Child Support--State Collection Procedures (Technical Amendment)	454(16)	2331(b)(1)	861	--	--	654	--
Child Support--Support of Parent Custodian (Technical Amendment)	454(16)	2332(d)(7)	862	--	--	655	--
Child Support--State Collection Procedures (Technical Amendment)	454(17)	2331(b)(2)	861	--	--	655	--
Child Support--Imposition of Fees for Collection (Technical Amendment)	454(17)	2333(b)(1)	862	--	--	655	--
Child Support--State Collection Procedures	454(18) New	2331(b)(3)	861	--	--	655	--
Child Support--Imposition of Fee for Collection (Technical Amendment)	454(18)	2333(b)(2)	862	--	--	655	--
Child Support--Intercept of Unemployment Benefits (Technical Amendment)	454(18)	2335(a)	863	--	--	--	--
Child Support--Imposition of Fee for Collection	454(19) New	2333(b)(3)	862	--	260, 302	655	986
Child Support--Intercept of Unemployment Benefits (Technical Amendments)	454(19)	2335(a)	863	--	--	--	--

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Child Support--Intercept of Unemployment Benefits	454(20) New	2335(a)	863	--	260, 303	--	986
Child Support--Not Discharged in Bankruptcy	456(b) New	2334(a)	863	--	260, 302	442, 523, 657	986
Child Support--Support of Parent Custodian (Technical Amendment)	457(b)	2332(e)(1)	862	--	--	658	--
Child Support--Support of Parent Custodian (Technical Amendment)	457(c)	2332(e)(2)	862	--	--	658	--
Child Support--Support of Parent Custodian (Technical Amendment)	460	2332(f)	862	--	--	659	--
Child Support--Collection from Federal Tax Refunds	464 New	2331(a)	860		261, 304	441, 520, 541, 659	985
Foster Care and Adoption Assistance--Conforming Amendment--Title XX	471(a)(10)	2353(r)	874	--	--	--	--
Maternal and Child Health Services--Authorization of Appropriations	501	2193(a)(3)	827	49	--	432, 482, 683	786
Maternal and Child Health Services--Purpose and Appropriations	501	2192(a)	818	49	--	432, 482, 540, 683	786
Maternal and Child Health Services--Allotment to States and Set Aside	502	2192(a)	819	52, 67	--	486, 684	787
Maternal and Child Health Services--Payment to States	503	2192(a)	821	52	--	486, 685	788
Maternal and Child Health Services--Use of Allotment Funds	504	2192(a)	821	53	--	486, 685	789
Maternal and Child Health Services--Report of Intended Expenditures and Statement of Assurances	505	2192(a)	822	57	--	487, 686	791

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Maternal and Child Health Services--Reports and Audits	506	2192(a)	823	60	--	487, 686	792
Maternal and Child Health Services--Criminal Penalty for False Statements	507	2192(a)	824	62	--	--	793
Maternal and Child Health Services--Nondiscrimination	508	2192(a)	825	63	--	--	793
Maternal and Child Health Services--Administration	509	2192(a)	825	--	--	485	794
Grants to States for the Blind--Elimination of Rehabilitation Services	1001	2184(c)(1)	817	--	--	688	--
Grants to States for the Blind--Repeal of Obsolete Authority for Medical Assistance	1003(a)(1) Stricken	2184(c)(2)(A)	817	336, 365	--	--	--
Grants to States for the Blind--Repeal of Obsolete Authority for Medical Assistance	1003(a)(2)	2184(c)(2)(B)	817	336, 365	--	--	--
Grants to States for the Blind--Repeal of Obsolete Authority for Medical Assistance (Conforming Amendment)	1003(a)(3)	2353(e)(1)(A)	872	336, 365	--	688	--
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Aid to the Permanently and Totally Disabled-- Repeal of Obsolete Authority for Medical Assistance	1403(a)(2)	2184(c)(2)(B)	817	336, 365	--	--	--
Aid to the Permanently and Totally Disabled-- Repeal of Obsolete Authority for Medical Assistance	1403(a)(3)	2353(b)(1)(A)	873	336, 365	--	710	--

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Aid to the Permanently and Totally Disabled-- Repeal of Obsolete Authority for Medical Assistance	1403(c) Repealed	2353(B)(2)	873	336, 365	--	710	--
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Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1601 (State)	2184(d)(3)(B)	817	336, 365	--	--	--
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Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(a) (State)	2184(d)(4)(B)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(a) (State)	2184(d)(4)(F)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance (Technical Amendment)	1602(a)(13) (State)	2184(d)(4)(C)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance (Technical Amendment)	1602(a)(14) (State)	2184(d)(4)(D)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(a)(15) (State) Stricken	2184(d)(4)(E)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(a)(16) (State) Stricken	2184(d)(4)(E)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(a)(17) (State) Stricken	2184(d)(4)(E)	817	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1602(b) (State)	2184(d)(4)(I)	818	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance (Technical Amendment)	1602(b)(2) (State)	2184(d)(4)(G)	818	336, 365	--	--	--

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Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance Stricken	1603(a)(1) (State) Stricken	2184(d)(5)(A)	818	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1603(a)(2)(A) (State)	2184(d)(5)(B)	818	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1603(a)(2)(B) (State)	2184(d)(5)(C)	818	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance (Technical Amendment)	1603(a)(2)(B) (State)	2353(m)(2)(A)	873	336, 365	--	--	--
Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance Stricken	1603(a)(3) (State) Stricken	2184(d)(5)(A)	818	336, 365	--	--	--
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Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1603(c) (State) Repealed	2353(m)(3)	873	336, 365	--	714	--
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Aid to Aged, Blind or Disabled--Repeal of Obsolete Authority for Medical Assistance	1605(b) (State) Stricken	2184(d)(6)(B)	818	336, 365	--	--	--
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Supplemental Security Income--Income and Resources--Retrospective Accounting	1612(b)(3)(SSI)	2341(b)(2)	865	--	261, 305, 348	442, 524, 715	987
Supplemental Security Income--Income and Resources--Retrospective Accounting	1612(b)(3)(SSI)	2341(b)(3)	865	--	261, 305, 348	442, 524, 715	989
Supplemental Security Income--Income and Resources--Retrospective Accounting	1612(b)(3)(SSI)	2341(b)(4)	865	--	261, 305, 348	442, 524, 716	987
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For a narrative account of the legislative history of
P.L. 97-35 and a summary of its provisions, see:
Social Security Bulletin, October 1981,
Vol. 44, No. 4



Public Law 97-35
97th Congress

An Act

To provide for reconciliation pursuant to section 301 of the first concurrent resolution on the budget for the fiscal year 1982.

Aug. 13, 1981
[H.R. 3982]

SHORT TITLE

SECTION 1. This Act may be cited as the “Omnibus Budget Reconciliation Act of 1981”.

Omnibus Budget
Reconciliation
Act of 1981.

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- Title XIX. Small business.
- Title XX. Veterans’ programs.
- Title XXI. Medicare, medicaid, and maternal and child health.
- Title XXII. Federal Old-Age, Survivors, and Disability Insurance program.
- Title XXIII. Public assistance programs.
- Title XXIV. Unemployment compensation.
- Title XXV. Trade adjustment assistance.
- Title XXVI. Low-income home energy assistance.
- Title XXVII. Health professions.

PURPOSE

SEC. 2. It is the purpose of this Act to implement the recommendations which were made by specified committees of the House of Representatives and the Senate pursuant to directions contained in part A of title III of the first concurrent resolution on the budget for the fiscal year 1982 (H. Con. Res. 115, 97th Congress), and pursuant to the reconciliation requirements which were imposed by such concurrent resolution as provided in section 310 of the Congressional Budget Act of 1974.

- (b) Section 1686 of such title is amended by inserting “to whom section 1662(a)(2) of this title is applicable” after “eligible veteran”. 38 USC 1686.
- (c) Section 1737 of such title is amended by inserting a comma and “before October 1, 1981,” after “shall be entitled”.
- (d) Section 1798(a) of such title is amended—
- (1) by striking out “Each” and inserting in lieu thereof “(1) Subject to paragraph (2) of this subsection, each”; and
 - (2) by adding at the end the following new paragraph:
- “(2) Except in the case of a veteran to whom section 1662(a)(2) of this title is applicable, no loan may be made under this subchapter after September 30, 1981.”.

EFFECTIVE DATES WITH RESPECT TO FLIGHT TRAINING

SEC. 2006. (a) Except as provided in subsection (b), the amendments made by sections 2003 and 2005 shall take effect on October 1, 1981. 38 USC 1631 note.

(b) The amendments made by such sections shall not apply to any person receiving educational assistance under section 1677 of title 38, United States Code, as such section was in effect on August 31, 1981, for the pursuit of a program of education (as defined in section 1652(b) of such title) in which such person was enrolled on that date, for as long as such person is continuously thereafter so enrolled and meets the requirements of eligibility for such assistance for the pursuit of such program under the provisions of chapters 34 and 36 of such title, as in effect on that date. 38 USC 1651 et seq., 1770 et seq.

TITLE XXI—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

SHORT TITLE OF SUBTITLES A, B, AND C; TABLE OF CONTENTS OF TITLE

SEC. 2100. Subtitles A, B, and C of this title may be cited as the “Medicare and Medicaid Amendments of 1981”. Medicare and Medicaid Amendments of 1981.

TABLE OF CONTENTS OF TITLE

TITLE XXI—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

Sec. 2100. Short title for subtitles A, B, and C; table of contents of title. 42 USC 1305 note.

Subtitle A—Provisions Relating to Medicare and Medicaid

CHAPTER 1—REIMBURSEMENT CHANGES

- Sec. 2101. Payments to promote closing and conversion of underutilized hospital facilities.
- Sec. 2102. Adjustment in payment for inappropriate hospital services.
- Sec. 2103. Limitation on medicare and medicaid payments for certain drugs.
- Sec. 2104. Withholding of payments for certain medicaid providers.

CHAPTER 2—OTHER ADMINISTRATIVE CHANGES

- Sec. 2105. Civil monetary penalties.
- Sec. 2106. Technical corrections for errors made by the Medicare and Medicaid Amendments of 1980.

CHAPTER 3—PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S)

- Sec. 2111. Making delegated review optional.
- Sec. 2112. Assessment of PSRO performance.

- Sec. 2113. Optional use of PSRO's under State medicaid plans.
- Sec. 2114. Secretarial determination in lieu of PSRO certification.

Subtitle B—Provisions Relating to Medicare

CHAPTER 1—CHANGES IN SERVICES AND BENEFITS

- Sec. 2121. Elimination of part A coverage of alcohol detoxification facility services.
- Sec. 2122. Elimination of occupational therapy as a basis for initial entitlement to home health services.

CHAPTER 2—CHANGES IN COINSURANCE, DEDUCTIBLES, AND COPAYMENTS

- Sec. 2131. Making part A coinsurance current with the year in which services furnished.
- Sec. 2132. Making part A coinsurance and deductible more current.
- Sec. 2133. Elimination of carryover from previous year of incurred expenses for meeting the part B deductible.
- Sec. 2134. Increase in part B deductible.

CHAPTER 3—REIMBURSEMENT CHANGES

- Sec. 2141. Limitation on routine nursing differential.
- Sec. 2142. Limitation on reasonable cost and reasonable charge for outpatient services.
- Sec. 2143. Limits on reimbursement to hospitals.
- Sec. 2144. Limits on reimbursement to home health agencies.
- Sec. 2145. Incentive reimbursement rate for renal dialysis services.
- Sec. 2146. Medicare payments secondary in cases of end stage renal disease services covered under certain group health policies.

CHAPTER 4—MISCELLANEOUS CHANGES

- Sec. 2151. Elimination of unlimited open enrollment.
- Sec. 2152. Utilization guidelines for provision of home health services.
- Sec. 2153. Repeal of statutory time limitation on agreement with skilled nursing facilities.
- Sec. 2154. Removal of limitation on number of medicare demonstration projects.
- Sec. 2155. Repeal of temporary delay in periodic interim payments (PIP).
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Subtitle C—Provisions Relating to Medicaid

CHAPTER 1—CHANGES IN PAYMENTS TO STATES

- Sec. 2161. Reduction in medicaid payments to States and offset for meeting Federal medicaid expenditure targets.
- Sec. 2162. Payments to territories.
- Sec. 2163. Eliminating time period limitation on payment of interest on disputed claims.
- Sec. 2164. Eliminating Federal matching for certain laboratory tests.
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CHAPTER 2—INCREASED FLEXIBILITY FOR STATES

- Sec. 2171. Coverage of, and services for, the medically needy.
- Sec. 2172. Flexibility in coverage of individuals aged 18-20.
- Sec. 2173. Reimbursement of hospitals.
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- Sec. 2175. Inapplicability and waiver of freedom-of-choice and other State plan requirements.
- Sec. 2176. Waiver to provide home and community-based services for certain individuals.
- Sec. 2177. Time limitation for action on requests for plan amendments and waivers.
- Sec. 2178. Flexibility in HMO and prepaid provider participation in State plans.

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- Sec. 2181. Repeal of EPSDT penalty.
- Sec. 2182. Flexibility in requiring collection of third-party payments.
- Sec. 2183. Permitting physician assistants and nurse practitioners to provide certain recertifications.
- Sec. 2184. Repeal of obsolete authority for medical assistance.

Subtitle D—Maternal and Child Health Services Block Grant

- Sec. 2191. Short title of subtitle.
- Sec. 2192. Maternal and child health services block grant.
- Sec. 2193. Repeals and conforming amendments.
- Sec. 2194. Effective date; transition.

Subtitle A—Provisions Relating to Medicare and Medicaid

CHAPTER 1—REIMBURSEMENT CHANGES

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

SEC. 2101. (a) Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

“SEC. 1884. (a) Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this title with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion. 42 USC 1395uu.

“(b) If the Secretary finds, after consideration of an application under subsection (a), that—

“(1) the hospital’s closure or conversion—

“(A) is formally initiated after September 30, 1981,

“(B) is expected to benefit the program under this title by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

“(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

“(2) in the case of a complete closure of a hospital—

“(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

“(B) the closure is not for replacement of the hospital, the Secretary may include as an allowable cost in the hospital’s reasonable cost (for the purpose of making payments to the hospital under this title) an amount (in this section referred to as a ‘transitional allowance’), as provided in subsection (c).

“(c)(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this title and shall recognize—

“(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

“(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this title, and

“(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this title; and

“(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this title, less any salvage value of the hospital.

“(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

“(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

“(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1861(v)(1) of this Act, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1814(b) and 1833(a)(2) of this Act.

“(c) A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.”

(2) Section 1903 of such Act is amended by inserting after subsection (d) the following new subsection:

“(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.”

(b)(1) Notwithstanding section 1884(a) of the Social Security Act, the Secretary of Health and Human Services may not establish under such section transitional allowances with respect to more than 50 hospitals prior to January 1, 1984.

(2) The Secretary of Health and Human Services shall evaluate the effectiveness of the program of transitional allowances established under section 1884 of the Social Security Act and shall, not later than January 1, 1983, report to the Congress on such evaluation and include in such report such recommendations for such legislative changes as he deems appropriate.

Post, pp. 787, 797.

42 USC 1395f,
1395l.

42 USC 1396b.

Ante, p. 785.
42 USC 1395uu
note.

Report to
Congress.

(c) The amendment made by subsection (a) shall apply only to services furnished by a hospital during any accounting year beginning on or after October 1, 1981.

Effective date.
42 USC 1395uu
note.

ADJUSTMENT IN PAYMENT FOR INAPPROPRIATE HOSPITAL SERVICES

SEC. 2102. (a)(1) Section 1861(v)(1)(G)(i) of the Social Security Act is amended by striking out "the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more" and inserting in lieu thereof "there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital".

42 USC 1395x.

(2) Clause (iv) of section 1861(v)(1)(G) of such Act is amended to read as follows:

"(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital."

(b)(1) The amendments made by subsection (a) shall apply to services provided on or after the first day of the first month beginning after the date of the enactment of this Act.

Effective date.
42 USC 1395x
note.

(2) For amendments respecting reimbursement for inappropriate hospital services under medicaid, see section 2173 of this subtitle.

LIMITATION ON MEDICARE AND MEDICAID PAYMENTS FOR CERTAIN DRUGS

SEC. 2103. (a)(1) Section 1862 of the Social Security Act is amended by inserting after subsection (b) the following new subsection:

42 USC 1395y.

"(c) No payment may be made under part B for any expenses incurred for—

"(1) a drug product—

"(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

21 USC 321 note.

"(B) which may be dispensed only upon prescription,

"(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 505 of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

21 USC 355.

"(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

"(2) any other drug product—

"(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

"(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order."

(2) The amendment made by paragraph (1) shall apply with respect to expenses incurred on or after October 1, 1981.

Effective date.
42 USC 1395y
note.

42 USC 1396b.

(b)(1) Section 1903(i) of such Act is amended by striking out the period at the end of paragraph (4) and inserting in lieu thereof “; or” and by adding after such paragraph the following new paragraph:

“(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c).”

Ante, p. 787.

Effective date.

42 USC 1396b
note.

(2) The amendment made by paragraph (1) shall apply to amounts expended on or after October 1, 1981.

WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICAID PROVIDERS

SEC. 2104. Part C of title XVIII of the Social Security Act is amended by adding after section 1884 (added by section 2101 of this subtitle) the following new section:

“WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICAID PROVIDERS

42 USC 1395w.

“SEC. 1885. (a) The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1866, and any person who has accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), where such institution or person—

42 USC 1395u.

“(1) has (or previously had) in effect an agreement with a State agency to furnish medical care and services under a State plan approved under title XIX, and

42 USC 1396.

“(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

“(b) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

“(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

“(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this title which shall be treated as a setoff against overpayments under title XIX, and

“(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XIX and to which the institution or person would otherwise be entitled under this title.

42 USC 1395i,
1395s.

“(c) Notwithstanding any other provision of this Act, from the trust funds established under sections 1817 and 1841, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under title XIX. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.”

CHAPTER 2—OTHER ADMINISTRATIVE CHANGES

CIVIL MONETARY PENALTIES

SEC. 2105. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1128 the following new section:

“CIVIL MONETARY PENALTIES

“SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines—

42 USC
1320a-7a.

“(1) is for a medical or other item or service—

“(A) that the person knows or has reason to know was not provided as claimed, or

“(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), 1862(d), or 1866(b)(2), or

94 Stat. 2619.
42 USC 1320a-7,
1320c-9,
1320c-11,
1320c-15.

“(2) is submitted in violation of an agreement between the person and the United States or a State agency, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for each item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

“(b)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty or assessment under subsection (a) only as authorized by the Attorney General pursuant to procedures agreed upon by them.

“(2) The Secretary shall not make a determination adverse to any person under subsection (a) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

Notice and
hearing.

“(c) In determining the amount or scope of any penalty or assessment imposed pursuant to subsection (a), the Secretary shall take into account—

“(1) the nature of claims and the circumstances under which they were presented,

“(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

“(3) such other matters as justice may require.

“(d) Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court the record in the proceeding as provided in section 2112 of title 28, United States Code.

Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

“(e) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

42 USC 1396.

“(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount equal to the State’s share of the amount paid by the State agency for such claim.

42 USC 1395i.

“(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

42 USC 1395i,
1395t.

“(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

“(3) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

“(f) A determination by the Secretary to impose a penalty or assessment under subsection (a) shall be final upon the expiration of the sixty-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (d) may not be raised

as a defense to a civil action by the United States to collect a penalty or assessment assessed under this section.

“(g) Whenever the Secretary’s determination to impose a penalty or assessment under subsection (a) becomes final, he shall notify the appropriate State or local medical or professional organization, and the appropriate Professional Standards Review Organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty or assessment has become final and the reasons therefor.

42 USC 1395aa,
1396a.

“(h) For the purposes of this subsection:

Definitions.

“(1) The term ‘State agency’ means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State’s program under title V of this Act.

42 USC 1396.
42 USC 701.

“(2) The term ‘claim’ means an application submitted by—

“(A) a provider of services or other person, agency, or organization that furnishes an item or service under title XVIII of this Act, or

42 USC 1395.

“(B) a person, agency, or organization that furnishes an item or service for which medical assistance is provided under title XIX of this Act, or

“(C) a person, agency, or organization that provides an item or service for which payment is made under title V of this Act or from an allotment to a State under such title, to the United States or a State agency, or agent thereof, for payment for health care services under title XVIII or XIX of this Act or for any item or service under title V of this Act.

“(3) The term ‘item or service’ includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

“(4) The term ‘agency of the United States’ includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a health insurance or medical services program under title XVIII or XIX of this Act.”.

(b) Section 1128 of such Act is amended—

94 Stat. 2619.
42 USC 1320a-7.

(1) by striking out “, for such period as he may deem appropriate,” in subsection (a)(1),

(2) by striking out “subsection (a)” in subsection (c) and inserting in lieu thereof “subsection (a) or (b)”,

(3) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively, and

(4) by inserting after subsection (a) the following new subsection:

“(b) Whenever the Secretary makes a final determination to impose a civil money penalty or assessment against a person (including an organization, agency, or other entity) under section 1128A relating to a claim under title XVIII or XIX, the Secretary—

“(1) may bar the person from participation in the program under title XVIII, and

“(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) may require each such agency to bar the person from participation in the program established by such plan for such period as he shall

specify, which in the case of an individual shall be the period established pursuant to paragraph (1), and

“(B) may waive the requirement of subparagraph (A) to bar a person from participation in such program where he receives and approves a request for such waiver with respect to that person from the State agency referred to in that subparagraph.”.

42 USC 1396a.

(c) Section 1902(a)(39) of such Act is amended by striking out “individual” and inserting in lieu thereof “person” each place it appears.

TECHNICAL CORRECTIONS FOR ERRORS MADE BY THE MEDICARE AND
MEDICAID AMENDMENTS OF 1980

SEC. 2106. (a) Section 1833(a)(2) of the Social Security Act (as amended by section 942 of the Medicare and Medicaid Amendments of 1980, P.L. 96-499) is amended by amending subparagraphs (A) and (B) to read as follows:

94 Stat. 2641.

42 USC 1395l.

42 USC 1395x.

“(A) with respect to home health services and to items and services described in section 1861(s)(10), the lesser of—

Ante, pp. 787,
797.

“(i) the reasonable cost of such services, as determined under section 1861(v), or

“(ii) the customary charges with respect to such services, or, if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

42 USC 1395f.

“(B) with respect to other services (except those described in subparagraph (C) of this paragraph)—

“(i) the lesser of—

“(I) the reasonable cost of such services, as determined under section 1861(v), or

“(II) the customary charges with respect to such services,

42 USC 1395cc.

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

“(ii) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

42 USC 1395n.

“(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section; and”.

(b)(1) Section 1835(a)(2) of such Act is amended—

(A) by adding “and” at the end of subparagraph (D), and

(B) by striking out “; and” at the end of subparagraph (E) and inserting in lieu thereof a period.

42 USC 1395q.

(2) The paragraph after section 1838(b) of such Act is amended by striking out “and such notice shall not be considered a disenrollment for the purposes of section 1837(b)”.

42 USC 1395p.

42 USC 1396b.

(3) Section 1903(n) of such Act is amended by striking out “of this section” after “section 1866”.

Effective date.

42 USC 1395f
note.

(c) The amendment made by subsection (a) is effective as of December 5, 1980, and the amendment made by subsection (b)(2) is effective as of April 1, 1981.

CHAPTER 3—PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S)

MAKING DELEGATED REVIEW OPTIONAL

SEC. 2111. Section 1155(e) of the Social Security Act is amended by striking out "shall utilize" and inserting in lieu thereof "may utilize". 42 USC 1320c-4.

ASSESSMENT OF PSRO PERFORMANCE

SEC. 2112. (a)(1) Section 1154 of the Social Security Act is amended by adding at the end the following new subsection: 42 USC 1320c-3.

"(g)(1) The Secretary shall, not later than September 30, 1981, identify and specify those requirements imposed by the Secretary with respect to the performance of Professional Standards Review Organizations which the Secretary will use for the assessment of the performance of such Organizations under this subsection. Such requirements shall include requirements relating to the effectiveness of such Organizations in (A) monitoring the quality of patient care, (B) reducing unnecessary utilization, and (C) managing its activities efficiently.

"(2) Based on such requirements, the Secretary shall assess and determine the relative performance of each of such Organizations designated, conditionally or otherwise, as of September 30, 1981.

"(3) If the Secretary determines that such an Organization has a relatively ineffective or inefficient performance, the Secretary may refuse to renew an agreement with the Organization under this part, except that, in exercising the Secretary's authority under this paragraph in fiscal year 1982, the sum of the number of Organizations with respect to which agreements are not renewed under this paragraph and under any other provision of this Act in the fiscal year may not exceed 30 percent of the number of such Organizations with agreements under this part on May 1, 1981."

(2)(A) Section 1152(d) of such Act is amended— 42 USC 1320c-1.

(i) by striking out "for a term of 12 months" and inserting in lieu thereof "for a term of not longer than 12 months";

(ii) by striking out "at such time and upon such reasonable notice to the organization as may be prescribed in regulations" and inserting in lieu thereof "upon 90 days notice to the organization"; and

(iii) by striking out "(after providing such organization with an opportunity for a formal hearing on the matter)".

(B) Sections 1152(d) and 1154(d) of such Act are each amended by adding at the end the following sentence: "A termination of an agreement by the Secretary under this subsection shall not be subject to judicial review."

(C) The amendment made by subparagraph (A)(iii) shall apply to agreements entered into on or after the date of the enactment of this Act. Effective date.
42 USC 1320c-1 note.

(D) The Secretary of Health and Human Services shall, not later than September 30, 1982, report to the Congress on his assessment (under section 1154(g) of the Social Security Act) of the relative performance of Professional Standards Review Organizations and on any determinations made not to renew agreements with such Organizations on the basis of such performance. 42 USC 1320c-3 note.

(b)(1) The first sentence of subsection (b) of section 1154 of such Act is amended— 42 USC 1320c-3.

(A) by striking out “(other than ancillary, ambulatory care, and long-term care services)” and

(B) by striking out “under subsection (f)(2) or subsection (f)(4)” and inserting in lieu thereof “under subsection (f)”.

(2) Subsection (f) of such section is amended—

(A) by striking out the parenthetical phrase in paragraph (1);

(B) by striking out paragraphs (2) and (3);

(C) by redesignating paragraph (4) as paragraph (2) and amending it to read as follows:

“(2) Where the Secretary finds that the review of particular health care services is cost-effective or yields other significant benefits, the Secretary may require Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) to review such services under this part.”; and

(D) by striking out the parenthetical phrase in paragraph (5) and redesignating such paragraph as paragraph (3).

OPTIONAL USE OF PSRO'S UNDER STATE MEDICAID PLANS

42 USC 1320c.

SEC. 2113. (a) Section 1151 of the Social Security Act is amended—

(1) by striking out “under this Act” and inserting in lieu thereof “under title XVIII of this Act”; and

(2) by striking out “the Social Security Act” and inserting in lieu thereof “title XVIII of this Act”.

42 USC 1320c-1.

(b) Section 1152(e) of such Act is amended by inserting “title XVIII of” before “this Act” each place it appears.

42 USC 1320c-3.

(c) Section 1152 of such Act is amended by striking out subsection (h), and section 1154 of such Act is amended by striking out subsection (e).

42 USC 1320c-4.

(d)(1) Section 1155(a) of such Act is amended by inserting “title XVIII of” before “this Act” each place it appears in paragraphs (1) and (2).

(2) Section 1155(a)(1) of such Act is amended by adding after and below subparagraph (C) the following new sentence:

“Each agreement with an Organization under this part shall require the Organization, if requested by a State with a plan approved under title XIX, to enter into a contract with the State, for the performance of review functions in the case of health care services and items provided under such State plan under terms and conditions similar to those contained in the agreement between the Organization and the Secretary under this part.”.

(3) Section 1155(a) of such Act is amended by striking out paragraph (7).

(4) Section 1155(e)(1) of such Act is amended by striking out “, or intermediate care facility, as defined in section 1905(c)” and “or intermediate care facility”.

42 USC 1320c-7.

(e)(1) Section 1158(a) of such Act is amended by striking out “under any title of this Act (other than title V)” and inserting in lieu thereof “under title XVIII” and by striking out “or any program established pursuant thereto”.

(2) Section 1158(c) of such Act is amended—

(A) by striking out “(subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act” and inserting in lieu thereof “(subject to section 1159) for purposes of payment under title XVIII”; and

(B) by striking out “, or single State agencies” and all that follows through “under title XIX”.

(3) Section 1158(d) of such Act is amended by striking out “or section 1902(h)”.

42 USC 1320c-7.

(f) Section 1159(a) of such Act is amended by striking out “under this Act (other than title V)” and inserting in lieu thereof “under title XVIII”.

42 USC 1320c-8.

(g)(1) Section 1160(a)(1) of such Act is amended by striking out “under this Act” the first place it appears and inserting in lieu thereof “under title XVIII (or under a State plan approved under title XIX, where the services furnished by the person are subject to review under a contract between the State and an Organization under section 1155(a))”, and by striking out “under this Act” the second place it appears and inserting in lieu thereof “under such title (or such State plan)”.

42 USC 1320c-9.

(2) Section 1160(b)(1) of such Act is amended by striking out “under this Act” and inserting in lieu thereof “under title XVIII”.

(h) Section 1162(e)(1) of such Act is amended by striking out “any program established by or pursuant to this Act” and inserting in lieu thereof “title XVIII”.

42 USC
1320c-11.

(i) Section 1164 of such Act is repealed.

Repeal.

(j) Section 1168 of such Act is amended—

42 USC
1320c-13.
42 USC
1320c-17.

(1) by inserting “and” at the end of paragraph (a);

(2) by striking out “and” at the end of paragraph (b);

(3) by striking out paragraph (c) and redesignating paragraphs (a) and (b) as paragraphs (1) and (2), respectively;

(4) by striking out “subsections (a), (b), and (c)” and inserting in lieu thereof “paragraphs (1) and (2)”;

(5) by amending the second sentence to read as follows: “The Secretary shall make such transfers of moneys between such funds as may be appropriate to settle accounts between them.”; and

(6) by striking out the second parenthetical phrase in the third sentence.

(k) Section 1171 of such Act is repealed.

Repeal.
42 USC
1320c-20.

(l) Section 1172(4) of such Act is amended by striking out “V, XI, XVIII, and XIX” and inserting in lieu thereof “XI and XVIII”.

42 USC
1320c-21.

(m) Section 1902 of such Act is amended by inserting after subsection (c) the following new subsection:

42 USC 1396a.

“(d) If a State contracts with a Professional Standards Review Organization designated, conditionally or otherwise, under part B of title XI for the performance of medical or utilization review functions required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such Organization (or Organizations) under the contract of the State’s authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such Organization (or Organizations) as the Secretary may prescribe.”.

42 USC 1320c.

(n) Section 1903(a)(3) of such Act is amended—

42 USC 1396b.

(1) by striking out “plus” at the end of subparagraph (B) and inserting in lieu thereof “and”, and

(2) by adding after subparagraph (B) the following new subparagraph:

“(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of

the State plan) as are attributable to the performance of medical and utilization review by a Professional Standards Review Organization under a contract entered into under section 1902(d); plus”

42 USC 1936a.
Effective date.
42 USC 1320c
note.

(c) The amendments made by this section apply to agreements with Professional Standards Review Organizations entered into on or after October 1, 1981.

SECRETARIAL DETERMINATION IN LIEU OF PSRO CERTIFICATION

42 USC 1395x.

SEC. 2114. Section 1861(v)(1)(G)(i) of the Social Security Act is amended by striking out “an organization or agency with review responsibility as is otherwise provided for under part A of title XI” and inserting in lieu thereof “the Secretary or such agent as the Secretary may designate”.

Subtitle B—Provisions Relating to Medicare

CHAPTER 1—CHANGES IN SERVICES AND BENEFITS

ELIMINATION OF PART A COVERAGE OF ALCOHOL DETOXIFICATION FACILITY SERVICES

42 USC 1395d.

SEC. 2121. (a) Section 1812(a) of the Social Security Act is amended—

- (1) by inserting “and” at the end of paragraph (2),
- (2) by striking out “; and” at the end of paragraph (3) and inserting in lieu thereof a period, and
- (3) by striking out paragraph (4).

42 USC 1395f.

(b) Section 1814(a)(2) of such Act is amended—

- (1) by inserting “or” at the end of subparagraph (D),
- (2) by striking out “or” at the end of subparagraph (E), and
- (3) by striking out subparagraph (F).

42 USC 1395x.

(c) Section 1861(u) of such Act is amended by striking out “detoxification facility,”.

(d) Subsection (bb) of section 1861 of such Act is repealed.

42 USC 1320c-3.

(e) The first sentence of section 1154(b) of such Act is amended by striking out “and to review of alcohol detoxification facility services”.

42 USC 1320c-4.

(f) Section 1155 of such Act is amended by striking out subsection (i).

42 USC 1320c-7.

(g) Section 1158 of such Act is amended—

- (1) by striking out “subsections (d) and (e)” in subsection (a) and inserting in lieu thereof “subsection (d)”, and
- (2) by striking out subsection (e).

42 USC 1395ll
note.

(h) Section 931 of the Medicare and Medicaid Amendments of 1980 (P.L. 96-499; 94 Stat. 2634) is amended by striking out subsection (f) (relating to a study of medicare coverage of certain additional detoxification-related services).

Effective date.

42 USC 1320c-3
note.

(i) The amendments made by this section (other than by subsection (h)) shall apply to services furnished in detoxification facilities for inpatient stays beginning on or after the tenth day after the date of the enactment of this Act.

ELIMINATION OF OCCUPATIONAL THERAPY AS A BASIS FOR INITIAL ENTITLEMENT TO HOME HEALTH SERVICES

42 USC 1395f,
1395n.

SEC. 2122. (a)(1) Sections 1814(a)(2)(D) and 1835(a)(2)(A) of the Social Security Act are each amended by striking out “needed skilled

nursing care on an intermittent basis, or physical, occupational, or speech therapy" and inserting in lieu thereof "needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy".

(b) The amendments made by this section shall apply to services furnished pursuant to plans of treatment implemented after the third month beginning after the date of the enactment of this Act.

Effective date.
42 USC 1395f
note.

CHAPTER 2—CHANGES IN COINSURANCE, DEDUCTIBLES, AND COPAYMENTS

MAKING PART A COINSURANCE CURRENT WITH THE YEAR IN WHICH SERVICES FURNISHED

SEC. 2131. (a) The first sentence of section 1813(b)(2) of the Social Security Act is amended by striking out "any spell of illness beginning" and inserting in lieu thereof "any inpatient hospital services or post-hospital extended care services furnished".

42 USC 1395e.

(b) The amendment made by subsection (a) is effective for inpatient hospital services or post-hospital extended care services furnished on or after January 1, 1982.

Effective date.
42 USC 1395e
note.

MAKING PART A COINSURANCE AND DEDUCTIBLE MORE CURRENT

SEC. 2132. (a) Section 1813(b)(2) of the Social Security Act is amended by striking out "\$40" and inserting in lieu thereof "\$45".

(b) The amendment made by subsection (a) shall apply to inpatient hospital services and post-hospital extended care services furnished in calendar years beginning with calendar year 1982.

42 USC 1395e
note.

ELIMINATION OF CARRYOVER FROM PREVIOUS YEAR OF INCURRED EXPENSES FOR MEETING THE PART B DEDUCTIBLE

SEC. 2133. (a) The first sentence of section 1833(b) of the Social Security Act is amended by striking out "the amount of the deductible for such calendar year" and all that follows through "(2)", and by redesignating clauses (3) and (4) as clauses (2) and (3), respectively.

42 USC 1395l.

(b) The amendments made by subsection (a) first apply to the deductible for calendar year 1982 with respect to expenses incurred on or after October 1, 1981.

Effective date.

INCREASE IN PART B DEDUCTIBLE

SEC. 2134. (a) Section 1833(b) of the Social Security Act is amended by striking out "\$60" and inserting in lieu thereof "\$75".

(b) The amendment made by subsection (a) shall take effect on January 1, 1982, and shall apply to the deductible for calendar years beginning with 1982.

Effective date.
42 USC 1395l
note.

CHAPTER 3—REIMBURSEMENT CHANGES

LIMITATION ON ROUTINE NURSING DIFFERENTIAL

SEC. 2141. (a) Section 1861(v)(1) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

42 USC 1395x.

“(J) Such regulations shall provide that an inpatient routine nursing salary cost differential shall be allowable as a reimbursable cost of hospitals, at a rate not to exceed 5 percent, to be applied under the same methodology used for the nursing salary cost differential for the month of April 1981.”.

Study.

42 USC 1395.

(b) The Comptroller General shall conduct a study to determine the extent (if any) to which the average cost of efficiently providing routine inpatient nursing care to individuals entitled to benefits under title XVIII of the Social Security Act exceeds the average cost of providing such care to other patients. The Comptroller General shall submit a final report with respect to the results of such study to the Congress within six months after the date of the enactment of this Act.

Effective date.
42 USC 1395x
note.

(c)(1) Subject to paragraph (2), the amendment made by subsection (a) shall apply to cost reporting periods ending after September 30, 1981.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.

LIMITATION ON REASONABLE COST AND REASONABLE CHARGE FOR OUTPATIENT SERVICES

Regulations.
42 USC 1395x.

SEC. 2142. (a) Section 1861(v)(1) of the Social Security Act is further amended by adding after subparagraph (J) (added by section 2141 of this subtitle) the following new subparagraph:

“(K) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services provided in an emergency room) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians’ offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians’ offices in the area to individuals entitled to benefits under this title.”.

42 USC 1395u.

(b) Section 1842(b)(3) of such Act is amended by adding at the end thereof the following new sentence: “The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K).”.

LIMITS ON REIMBURSEMENT TO HOSPITALS

Supra.

SEC. 2143. (a) Section 1861(v)(1) of the Social Security Act is further amended by adding after subparagraph (K) (added by section 2142 of this subtitle) the following new subparagraph:

“(L) The Secretary, in determining the amount of the payments that may be made under this title with respect to routine operating costs for the provision of general inpatient hospital services, may not recognize as reasonable (in the efficient delivery of health services) routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceed 108 percent of the mean of such routine operating costs per diem for hospitals, or, in

the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary may determine. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.”.

(b)(1) Subject to paragraph (2), the amendment made by subsection (a) shall apply to costs reporting periods ending after September 30, 1981.

Effective date.
42 USC 1395x
note.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.

LIMITS ON REIMBURSEMENT TO HOME HEALTH AGENCIES

SEC. 2144. (a) Subparagraph (L) of section 1861(v)(1) of the Social Security Act (added by section 2143 of this subtitle) is amended by inserting “(i)” after “(L)” and by adding at the end the following new clause:

42 USC 1395x.

“(ii) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) the 75th percentile of such costs per visit for home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the mean of the costs of such agencies or otherwise) as the Secretary may determine. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.”.

(b)(1) Subject to paragraph (2), the amendment made by subsection (a) shall apply to cost reporting periods ending after September 30, 1981.

Effective date.
42 USC 1395x
note.

(2) In the case of a cost reporting period beginning before October 1, 1981, any reduction in payments resulting from the amendment made by subsection (a) shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.

INCENTIVE REIMBURSEMENT RATE FOR RENAL DIALYSIS SERVICES

SEC. 2145. (a) Section 1881(b) of the Social Security Act is amended—

42 USC 1395rr.

(1) by inserting “and consistent with any regulations promulgated under paragraph (7)” in paragraph (2)(B) after “section 1861(v)”;

(2) by striking out the second sentence of paragraph (2)(B);

(3) by inserting “(which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis)” in paragraph (3)(B) after “or other basis”;

(4) by inserting “or on the basis of a method established under paragraph (7)” before the period at the end of paragraph (4);

(5) by inserting “(except as may be provided in regulations under paragraph (7))” in the second sentence of paragraph (6) after “in no event” and by striking out “70 percent” in such sentence and inserting in lieu thereof “75 percent”;

(6) by inserting "(including methods established under paragraph (7))" in the fifth sentence of paragraph (6) after "any other procedure";

(7) by redesignating paragraphs (7) through (9) as paragraphs (8) through (10), respectively; and

(8) by inserting after paragraph (6) the following new paragraph:

"(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas). The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6)."

(b) The amendments made by subsection (a) apply to services furnished on or after October 1, 1981, and the Secretary of Health and Human Services shall first promulgate regulations to carry out section 1881(b)(7) of the Social Security Act not later than October 1, 1981.

MEDICARE PAYMENTS SECONDARY IN CASES OF END STAGE RENAL DISEASE SERVICES COVERED UNDER CERTAIN GROUP HEALTH POLICIES

SEC. 2146. (a) Section 1862(b) of the Social Security Act is amended by inserting "(1)" after "(b)" and by adding at the end thereof the following new paragraph:

"(2)(A) In the case of an individual who is entitled to benefits under part A or is eligible to enroll under part B solely by reason of section 226A, payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service furnished during the period described in subparagraph (C) to the extent that payment with respect to expenses for such item or service (i) has been made under any group health plan (as defined in section 162(h)(2) of the Internal Revenue Code of 1954) or (ii) the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this title.

"(B) Any payment under this title with respect to any item or service to an individual described in subparagraph (A) during the period described in subparagraph (C) shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under a plan described in subparagraph (A). The Secretary may waive the provisions of this subpara-

Effective date.
42 USC 1395rr
note.

Supra.

42 USC 1395y.

26 USC 162.

graph in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

“(C) The provisions of subparagraphs (A) and (B) shall apply to an individual only during the 12-month period which begins with the earlier of—

“(i) the month in which a regular course of renal dialysis is initiated, or

“(ii) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under this title (if he had filed an application for such benefits) under the provisions of section 226A(b)(1)(B).

“(D) Where payment for an item or service under such plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

“(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such group health plan; and

“(ii) such payment under this title, when combined with the amount payable under such plan, may not exceed the combined amount which would have been payable under this title and such plan if this paragraph were not in effect.”.

(b) Section 162 of the Internal Revenue Code of 1954 (relating to trade or business expenses) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

26 USC 162.

“(h) GROUP HEALTH PLANS.—

“(1) GENERAL RULE.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if the plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner.

“(2) GROUP HEALTH PLAN.—For purposes of this subsection the term ‘group health plan’ means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(e)) to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.”.

(c)(1) The amendments made by subsection (a) shall become effective on October 1, 1981.

(2) The amendments made by subsection (b) shall be effective with respect to taxable years beginning on or after January 1, 1982.

Effective date.

42 USC 1395y

note.

26 USC 162 note.

CHAPTER 4—MISCELLANEOUS CHANGES

ELIMINATION OF UNLIMITED OPEN ENROLLMENT

SEC. 2151. (a)(1) Section 1837(e) of the Social Security Act is amended to read as follows:

42 USC 1395p.

“(e) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.”.

(2) Section 1837(g)(3) of such Act is amended by striking out “the month in which the individual files an application establishing such entitlement” and inserting in lieu thereof “the earlier of the then

current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)".

42 USC 1395q.

(3) Section 1838(a)(2)(E) of such Act is amended by striking out "the first day of the third month" and inserting in lieu thereof "the July 1".

42 USC 1395r.

(4) The second sentence of section 1839(d) of such Act is amended by striking out "the month after the month in which he reenrolled" and inserting in lieu thereof "the close of the enrollment period in which he reenrolled".

Effective date.
42 USC 1395p
note.

(b) The amendments made by this section shall not apply to enrollments pursuant to written requests for enrollment filed before October 1, 1981.

UTILIZATION GUIDELINES FOR PROVISION OF HOME HEALTH SERVICES

42 USC 1395y.

SEC. 2152. (a) Section 1862 of the Social Security Act is amended by adding at the end the following new subsection:

"(f) The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise."

42 USC 1395y
note.

(b) The Secretary of Health and Human Services shall establish, and provide for the implementation of, the guidelines described in section 1862(f) of the Social Security Act not later than October 1, 1981.

REPEAL OF STATUTORY TIME LIMITATION ON AGREEMENT WITH SKILLED NURSING FACILITIES

42 USC 1395cc.

SEC. 2153. Section 1866(a)(1) of the Social Security Act is amended by striking out the second sentence.

REMOVAL OF LIMITATION ON NUMBER OF MEDICARE DEMONSTRATION PROJECTS

42 USC 1395b-1
note.

SEC. 2154. Section 903 of the Medicare and Medicaid Amendments of 1980 (P.L. 96-499; 94 Stat. 2615) is amended by striking out subsection (c).

REPEAL OF TEMPORARY DELAY IN PERIODIC INTERIM PAYMENTS (PIP)

42 USC 1395g
note.

SEC. 2155. Section 959 of the Medicare and Medicaid Amendments of 1980 (P.L. 96-499; 94 Stat. 2650) is repealed.

STATUTORY DEADLINES FOR IMPLEMENTING AFDC HOME HEALTH AIDE DEMONSTRATION PROJECTS

42 USC 632a.

SEC. 2156. Section 966 of the Medicare and Medicaid Amendments of 1980 (P.L. 96-499; 94 Stat. 2652) is amended—

(1) by adding at the end of subsection (c)(2) the following new sentence: "The Secretary shall, not later than October 1, 1981, establish such guidelines and establish such regulations as may be necessary to assure that agreements are entered into under this section by not later than January 1, 1982.", and

(2) by striking out "The Secretary" in subsection (h) and inserting in lieu thereof "The Secretary shall, during January

1982, submit to the Congress a report on steps taken by January 1, 1982, to enter into agreements under this section, including a general description of each of such agreements entered into by such date and the timetable under which he anticipates other such agreements will be entered into. Thereafter, the Secretary”.

Subtitle C—Provisions Relating to Medicaid

CHAPTER 1 —CHANGES IN PAYMENTS TO STATES

REDUCTION IN MEDICAID PAYMENTS TO STATES AND OFFSET FOR MEETING FEDERAL MEDICAID EXPENDITURE TARGETS

SEC. 2161. (a) Section 1903 of the Social Security Act is amended by adding at the end the following new subsection: 42 USC 1396b.

“(s)(1)(A) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State is otherwise entitled to receive under this title for any quarter in—

“(i) fiscal year 1982, shall be reduced by 3 percent,

“(ii) fiscal year 1983, shall be reduced by 4 percent, and

“(iii) fiscal year 1984, shall be reduced by 4.5 percent,

of the amount to which the State is otherwise entitled (without regard to payments under subsection (t) and without regard to payments for claims relating to expenditures made before fiscal year 1981).

“(B) No reduction may be made under subparagraph (A) for a quarter unless, as of the first day of the quarter, the Secretary has promulgated and has in effect final regulations (on an interim or other basis) implementing paragraphs (10)(C) and (13)(A) of section 1902(a) (as amended by the Medicare and Medicaid Amendments of 1981).

“(C) For purposes of this paragraph, the term ‘State’ only includes the fifty States and the District of Columbia and does not include any State which did not have a plan approved under this title as of July 1, 1981.

“(2) The percentage reduction imposed by paragraph (1) for a State for a quarter shall be reduced—

“(A) by one percentage point if the State has a qualified hospital cost review program (described in paragraph (3)) for the quarter,

“(B) by one percentage point if the State has a high unemployment rate (as determined under paragraph (4)) for the quarter, and

“(C) by one percentage point if the total amount of the State's third party and fraud and abuse recoveries (as defined in paragraph (5)(A)) for the previous quarter is equal to or exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State under this title for that previous quarter (without regard to payments under subsection (t)).

“(3) For purposes of paragraph (2)(A), a State has a qualified hospital cost review program for a calendar quarter if such program meets the following requirements:

“(A) The program must have been established by statute and in effect on July 1, 1981, and at the beginning of the quarter.

“(B) The program must be operated directly by the State and must apply (i) to substantially all nonfederal acute care hospitals (as defined by the Secretary) in the State and (ii) to review of

42 USC 1395.

either all revenues or expenses for inpatient hospital services (other than revenues under title XVIII of this Act, unless approved by the Secretary) or at least 75 percent of all revenues or expenses for inpatient hospital services (including revenues under title XVIII of this Act).

“(C) The State must provide the Secretary with satisfactory assurances as to the equitable treatment under the program of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients.

“(D) The Secretary determines that the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the State during the most recent calendar year ending at least nine months before such quarter (or, at the State’s option, during the 2 or 3 calendar-year period ending with that calendar year) is at least two percentage points less than the annual rate of increase during that calendar year (or that period, as the case may be) in such costs per capita or per admission for hospitals located in the United States (excluding from such computation, with respect to any calendar year in any period, any State which had in existence a qualified hospital cost review program (or, in the case of periods before January 1, 1982, had a hospital cost review program which the Secretary determines met for such periods the provisions of subparagraphs (A), (B), and (C) of this paragraph) during that entire calendar year).

“(4)(A) For purposes of paragraph (2)(B), a State has a high unemployment rate with respect to a quarter if the average of the monthly unemployment rates (as determined by the Bureau of Labor Statistics) for the State for the three months immediately before such quarter is equal to or greater than 150 percent of the average of such rates for the United States for such months.

“(B) For purposes of subparagraph (A), the term ‘United States’ only includes the fifty States and the District of Columbia.

“(5)(A) For purposes of paragraph (2)(C), the term ‘third party and fraud and abuse recoveries’ means, for a State for a previous quarter—

“(i) the total amount that State demonstrates to the Secretary that it has recovered or diverted in the quarter on the basis of (I) third-party payments (described in section 1902(a)(25)), (II) the operation of its State medicaid fraud control unit (defined in subsection (q)), and (III) other fraud or abuse control activities, plus

“(ii) any amount carried forward from the previous quarter under subparagraph (B).

Subclause (I) of clause (i) shall only apply to quarters during fiscal year 1982.

“(B) If the total amount of the State’s third party and fraud and abuse recoveries (defined in subparagraph (A)) for a quarter (beginning on or after October 1, 1981) exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State under this title for that quarter (without regard to subsection (t)), the amount of such excess shall be carried forward to the following quarter for purposes of clause (ii) of subparagraph (A).”

(b) Section 1902 of such Act is further amended by adding after subsection (s) (added by subsection (a) of this section) the following new subsection:

“(t)(1) The Secretary shall determine for each State (as defined in subsection (s)(1)(C)) for each of fiscal years 1982, 1983, and 1984, a

42 USC 1396b.

target amount of Federal medicaid expenditures. Such target amount for a State for fiscal year—

“(A) 1982, is equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this title (other than interest paid under subsection (d)(5), without taking into account reductions in payment under subsection (s) or additional payments under this subsection, and without regard to payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State;

“(B) 1983, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1983; and

“(C) 1984, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1984.

“(2) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State (with a State plan approved under this title) is otherwise entitled to receive for the first quarter of any fiscal year (beginning with fiscal year 1983 and ending with fiscal year 1985) shall be supplemented by an amount equal to the lesser of—

“(A) the amount by which the Secretary determines or estimates (subject to appropriate subsequent adjustments) the Federal share of expenditures under this title (other than interest paid under subsection (d)(5), without taking into account reductions in payment under subsection (s) or payments under this subsection, without regard to payments for claims relating to expenditures made prior to October 1, 1980, and subject to paragraph (3) of this subsection) under the State's plan for the previous fiscal year was less than the target amount of Federal medicaid expenditures for that State for that fiscal year determined under paragraph (1), or

“(B) the amount of the reductions imposed with respect to the State under subsection (s) for the quarters in the previous fiscal year.

“(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal year 1984 (in the case of the payment which may be made for the first quarter of fiscal year 1985), the Federal medical assistance percentage for fiscal year 1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1983, disregarding any change in such percentage between fiscal year 1983 and fiscal year 1984.”

(c)(1) Effective for calendar quarters beginning on or after October 1, 1984, subsection (s) of section 1902 of the Social Security Act (added by subsection (a) of this section) is repealed. *Ante*, p. 803.

(2) Effective after payments for the first quarter of fiscal year 1985, subsection (t) of section 1902 of the Social Security Act (added by subsection (b) of this section) is repealed. *Ante*, p. 804.

PAYMENTS TO TERRITORIES

42 USC 1301.

SEC. 2162. (a)(1) Section 1101(a)(1) of the Social Security Act is amended (1) by striking out "American Samoa and" in the third sentence and inserting in lieu thereof "American Samoa, the Northern Mariana Islands, and", and (2) by inserting after the third sentence the following new sentence: "Such term when used in title XIX also includes the Northern Mariana Islands."

42 USC 1396d.

(2) Clause (2) of section 1905(b) of such Act is amended by striking out "and Guam" and inserting in lieu thereof "Guam, and the Northern Mariana Islands".

42 USC 1308.

(b)(1) Subsection (c) of section 1108 of such Act is amended to read as follows:

42 USC 1396.

"(c) The total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

"(1) Puerto Rico shall not exceed \$45,000,000,

"(2) the Virgin Islands shall not exceed \$1,500,000,

"(3) Guam shall not exceed \$1,400,000, and

"(4) the Northern Mariana Islands shall not exceed \$350,000."

Effective date.
42 USC 1308
note.

(2) The amendment made by paragraph (1) shall apply to fiscal years beginning with fiscal year 1982.

ELIMINATING TIME PERIOD LIMITATION ON PAYMENT OF INTEREST ON DISPUTED CLAIMS

42 USC 1396b.

SEC. 2163. Section 1903(d)(5) of the Social Security Act is amended by striking out "(but not to exceed a period of twelve months)" and all that follows through "disallowances made thereafter)".

ELIMINATING FEDERAL MATCHING FOR CERTAIN LABORATORY TESTS

SEC. 2164. (a) Section 1903(i) of the Social Security Act, as amended by section 2103 of this subtitle, is further amended by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or" and by adding at the end the following new paragraph:

"(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner."

Effective date.
42 USC 1396b
note.

(b) The amendments made by subsection (a) shall apply to tests occurring on or after October 1, 1981.

STUDY OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FORMULA AND OF ADJUSTMENTS OF TARGET AMOUNTS FOR FEDERAL MEDICAID EXPENDITURES

42 USC 1396d
note.

SEC. 2165. (a) The Comptroller General, in consultation with the Advisory Committee for Intergovernmental Relations, shall conduct a study of—

42 USC 1396d.

(1) the formula, under section 1905(b) of the Social Security Act, defining the Federal medical assistance percentage, as it applies to distribution of Federal funds to States (as defined for purposes of title XIX of such Act) under that Act, and

(2) the validity and equity of any adjustment to the target amount of Federal medical expenditures (under section 1903(t) of the Social Security Act, added by section 2161 of this subtitle) for all States or any particular State which ought to be made for fiscal year 1983 or fiscal year 1984 (including methodology for calculating and implementing such adjustments) to reflect eco-

Ante, p. 804.

conomic and demographic factors affecting such State which are out of the ordinary sphere of control of such State.

Specifically, pursuant to paragraph (1) the Comptroller General shall examine the feasibility and consequences of revising the medicaid matching formula so as to take into account the relative economic positions and needs of the different States, the different amounts of support and income payments made by different States under the Social Security Act, the relative cost of living and the unemployment rates in the different States, the relative taxable wealth and amount of taxes raised per capita by the different States, and other relevant factors bearing on an equitable distribution of Federal funds to States under that Act.

42 USC 1305.

(b) The Comptroller General shall report to the Congress on the study required under this section not later than October 1, 1982.

CHAPTER 2—INCREASED FLEXIBILITY FOR STATES

COVERAGE OF, AND SERVICES FOR, THE MEDICALLY NEEDY

SEC. 2171. (a) Section 1902(a)(10) of the Social Security Act is amended—

42 USC 1396a.

(1) by amending subparagraph (A) to read as follows:

“(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;”

42 USC 1396d.

42 USC 301,
1201, 1351, 1381,
601; 94 Stat. 501.
42 USC 670.

(2) by striking out “clause” each place it appears in subparagraph (B) and inserting in lieu thereof “subparagraph” and by striking out “and” at the end of subparagraph (B); and

(3) by striking out paragraph (C) and by inserting in lieu thereof the following:

“(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A), then—

“(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance and (II) the amount, duration, and scope of medical assistance made available to individuals in the group;

“(ii) the plan must make available medical assistance—

“(I) to individuals described in section 1905(a)(i), and

“(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

“(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

“(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

“(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;”.

(b) Section 1902(a)(13) of such Act is amended by striking out subparagraphs (A), (B), and (C).

(c) The amendments made by this section shall become effective on the date of the enactment of this Act.

42 USC 1396a.

Effective date.
42 USC 1396a
note.

FLEXIBILITY IN COVERAGE OF INDIVIDUALS AGED 18-20

SEC. 2172. (a) Paragraph (2) of section 1902(b) of the Social Security Act is amended to read as follows:

“(2) any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of title IV;”.

(b)(1) Clause (i) of section 1905(a) of such Act is amended to read as follows:

“(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals;”.

(2) Section 1905(a)(ii) of such Act is amended by striking out “, except for section 406(a)(2).”.

(c) The amendments made by this section shall become effective on the date of the enactment of this Act.

42 USC 1396d.

Effective date.
42 USC 1396a
note.

REIMBURSEMENT OF HOSPITALS

SEC. 2173. (a)(1) Section 1902(a)(13) of the Social Security Act is amended—

(A) by striking out subparagraph (D);

(B) in subparagraph (E)—

(i) by striking out “skilled nursing facility and intermediate care facility” and inserting in lieu thereof “hospital, skilled nursing facility, and intermediate care facility”;

(ii) by inserting “and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G))” after “determined in accordance with methods and standards developed by the State”;

(iii) by inserting before the first semicolon the following: “and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality”; and

42 USC 1396a.

42 USC 1395x.

(iv) by striking out “each skilled nursing or intermediate care facility” and inserting in lieu thereof “each hospital, skilled nursing facility, and intermediate care facility”; and
(C) by redesignating subparagraphs (E) and (F) as subparagraphs (A) and (B), respectively.

(2) Section 1902(a)(20) of such Act is amended—

42 USC 1396a.

(A) by inserting “and” at the end of subparagraph (B);

(B) by striking out “and” at the end of subparagraph (C); and

(C) by striking out subparagraph (D).

(b)(1) Subsection (h) of section 1902 of such Act is repealed.

(2) The amendment made by paragraph (1) shall not apply with respect to services furnished before the date the Secretary of Health and Human Services first promulgates and has in effect final regulations (on an interim or other basis) to carry out section 1902(a)(13)(A) of the Social Security Act (as amended by this subtitle).

42 USC 1396a
note.

(c) Part A of title XI of such Act is amended by adding after section 1134 the following new section:

“DEVELOPMENT OF MODEL PROSPECTIVE RATE METHODOLOGY

“SEC. 1135. (a) The Secretary shall develop a model system or systems for the payment of hospitals for inpatient hospital services on a prospective basis which may be applied for reimbursement of hospitals under title XVIII or under a State plan approved under title XIX.

42 USC 1320b-5.

“(b) The Secretary shall report to the Congress on the development of such system or systems not later than July 31, 1982.”.

42 USC 1395,
1396.

REMOVAL OF MEDICAID REASONABLE CHARGE LIMITATION

SEC. 2174. (a) Section 1902(a)(30) of the Social Security Act is amended by striking out “(including payments)” and all that follows through “reasonable charges” and inserting in lieu thereof “are”.

42 USC 1396a.

(b) Section 1903(i) of such Act is amended by striking out paragraph (1).

42 USC 1396b.

(c) The amendments made by this section shall apply to services furnished on or after October 1, 1981.

Effective date.
42 USC 1396a
note.

INAPPLICABILITY AND WAIVER OF FREEDOM-OF-CHOICE AND OTHER STATE PLAN REQUIREMENTS

SEC. 2175. (a) Paragraph (23) of section 1902(a) of the Social Security Act is amended—

(1) by inserting “except as provided in section 1915 and” after “(23)”, and

(2) by striking out all that follows the first semicolon.

(b) Title XIX of the Social Security Act is amended by adding at the end the following new section:

“PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

“SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

42 USC 1396n.

“(1) has entered into—

“(A) a contract with an organization which has agreed to provide care and services in addition to those offered under

the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

42 USC 1396d.

“(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

“(i) adequate services or devices will be available under such arrangements, and

“(ii) any such laboratory services will be provided only through laboratories—

42 USC 1395x.

“(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs (11) and (12) of section 1861(s), and such additional requirements as the Secretary may require, and

42 USC 1395c,
1395j.

“(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; or

“(2) restricts—

“(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or

“(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care,

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

42 USC 1396a,
1396b.

“(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 and section 1903(m) as may be necessary for a State—

“(1) to implement a case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain primary care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

“(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

“(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

“(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

“(c) No waiver under this section may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

“(d)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

“(2) The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.”.

Report to Congress.

(d)(1) Section 1902(a)(9) of such Act is amended—

42 USC 1396a.

(A) by striking out “and” at the end of subparagraph (A),

(B) by striking out the semicolon at the end of subparagraph (B) and inserting in lieu thereof “, and”, and

(C) by adding after subparagraph (B) the following new subparagraph:

“(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (11) and (12) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);”.

42 USC 1395x.

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after October 1, 1981.

Effective date.
42 USC 1396a note.
42 USC 1396.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

WAIVER TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR
CERTAIN INDIVIDUALS

Ante, p. 809.

SEC. 2176. Section 1915 of the Social Security Act (added by section 2175 of this subtitle) is amended—

(1) by inserting “(other than a waiver under subsection (c))” in subsection (c) after “No waiver under this section”, and

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

“(c)(1) The Secretary may by waiver provide that a State plan approved under this part may include as ‘medical assistance’ under such plan home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

“(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

“(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

“(B) the State will provide, with respect to individuals who are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan and who may require such services, for an evaluation of the need for such services;

“(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of skilled nursing facility or intermediate care facility services;

“(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

“(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

“(3) A waiver granted under this subsection may include a waiver of the requirements of subsection (a)(1) (relating to statewideness) and subsection (a)(10) of section 1902. A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met.

“(4) A waiver granted under this section may, consistent with paragraph (2)—

“(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

“(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, home-maker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve.”.

TIME LIMITATION FOR ACTION ON REQUESTS FOR PLAN AMENDMENTS AND WAIVERS

SEC. 2177. (a) Section 1915 of the Social Security Act (added by section 2175 of this subtitle) is further amended by adding at the end thereof the following new subsection:

Ante, p 812.

“(f) A request to the Secretary from a State for a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.”.

(b) The amendment made by this section shall become effective 90 days after the date of the enactment of this Act.

Effective date.
42 USC 1396n
note.

FLEXIBILITY IN HMO AND PREPAID PROVIDER PARTICIPATION IN STATE PLANS

SEC. 2178. (a)(1) Paragraph (1)(A) of section 1903(m) of the Social Security Act is amended by striking out “means” and all that follows through the end thereof and inserting in lieu thereof the following: “means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which—

42 USC 1396b.

“(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

“(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization’s insolvency.”.

42 USC 300e-9.

(2) Paragraph (2)(A) of section 1903(m) of such Act is amended—
(A) by striking out “and” at the end of clause (i),

42 USC 1396b.

(B) by striking out "one-half of the membership of the entity" in clause (ii) and inserting in lieu thereof "75 percent of the membership of the entity which is enrolled on a prepaid basis";

(C) by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon, and

(D) by adding at the end the following new clauses:

"(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis;

"(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

"(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

"(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment; and

"(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services."

(3) Paragraph (2) of such section is further amended by adding after subparagraph (C) the following new subparagraph:

"(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that (i) special circumstances warrant such modification or waiver, and (ii) the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII."

(b) Section 1902(e) of such Act is amended by inserting "(1)" after "(e)" and by adding at the end the following new paragraph:

"(2)(A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) under a contract described in section 1903(m)(2)(A) and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits

42 USC 1395.

42 USC 1396a.

42 USC 300e.

42 USC 1396b.

until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such organization.

"(B) For purposes of subparagraph (A), the term 'minimum enrollment period' means, with respect to an individual's enrollment with a health maintenance organization under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization becomes effective."

"Minimum enrollment period."

(c) The amendments made by this section shall apply with respect to services furnished, under a State plan approved under title XIX of the Social Security Act, on or after October 1, 1981; except that such amendments shall not apply with respect to services furnished by a health maintenance organization under a contract with a State entered into under such title before October 1, 1981 unless the organization requests that such amendments apply and the Secretary of Health and Human Services and the single State agency (administering or supervising the administration of the State plan under such title) agree to such request.

42 USC 1396a note.

42 USC 1396.

(d) The Secretary of Health and Human Services shall conduct a study evaluating the extent of, and reasons for, the termination by medicaid beneficiaries of their memberships in health maintenance organizations. In conducting such study, the Secretary shall place special emphasis on the quantity and quality of medical care provided in health maintenance organizations and the quality of such care when provided on a fee-for-service basis. The Secretary shall submit an interim report to the Congress, within two years after the date of the enactment of this Act, and a final report within five years from such date containing, respectively, the interim and final findings and conclusions made as a result of such study.

42 USC 1396a note.

Report to Congress.

CHAPTER 3—MISCELLANEOUS CHANGES

REPEAL OF EPSDT PENALTY

SEC. 2181. (a)(1) Subsection (g) of section 403 of the Social Security Act is repealed.

42 USC 603.

(2) Section 1902(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (42),

42 USC 1396a.

(B) by striking out the period at the end of paragraph (43) and inserting in lieu thereof "; and", and

(C) by inserting after paragraph (43) the following new paragraph:

"(44) provide for—

"(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(a)(4)(B),

42 USC 1396d.

"(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

"(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services."

(b) The amendment made by subsection (a)(1) shall apply to reductions for calendar quarters beginning on or after June 30, 1974, and

Effective date.
42 USC 603 note.

the amendments made by subsection (a)(2) shall take effect on October 1, 1981.

FLEXIBILITY IN REQUIRING COLLECTION OF THIRD-PARTY PAYMENTS

42 USC 1396a.

SEC. 2182. Section 1902(a)(25)(C) of the Social Security Act is amended by inserting "and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery" after "of the individual".

PERMITTING PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS TO PROVIDE CERTAIN RECERTIFICATIONS

42 USC 1396b.

SEC. 2183. (a) Section 1903(g)(1)(A) of the Social Security Act is amended—

(1) by striking out "(and recertifies" and inserting in lieu thereof "(and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies", and

(2) by inserting "(or, in the case of services that are intermediate care facility services described in section 1905(d), every year)" after "every 60 days".

Effective date.
42 USC 1396b
note.

(b) The amendments made by subsection (a) shall apply to payments made to States for calendar quarters beginning on or after October 1, 1981.

REPEAL OF OBSOLETE AUTHORITY FOR MEDICAL ASSISTANCE

SEC. 2184. (a)(1) The heading of title I of the Social Security Act is amended by striking out "AND MEDICAL ASSISTANCE".

42 USC 301.

(2) Section 1 of such Act is amended—

(A) by striking out "(a)" the first place it appears in the first sentence,

(B) by striking out ", (b) of enabling" and all that follows through "for self-care" in the first sentence, and

(C) by striking out ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged" in the second sentence.

42 USC 302.

(3) Section 2 of such Act is amended—

(A) by striking out "AND MEDICAL ASSISTANCE" in the heading;

(B) by striking out ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged" in subsection (a) before paragraph (1);

(C) by striking out "; and" at the end of subsection (a)(10) and inserting in lieu thereof a period; and

(D) by striking out paragraphs (11), (12), and (13) of subsection (a).

42 USC 303.

(4) Section 3 of such Act is amended—

(A) by striking out paragraphs (1) and (3) of subsection (a);

(B) by amending paragraph (2) of subsection (a) to read as follows:

"(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of old-age assistance for such month; plus"; and

(C) by striking out subsection (d).

(5) Section 6 of such Act is amended by striking out subsections (b) and (c). 42 USC 306.

(b)(1) Section 403 of such Act is amended— 42 USC 603.

(A) by striking out “(including expenditures for premiums” and all that follows through “the cost thereof)” in subsection (a)(1) in the matter before subparagraph (A);

(B) by striking out “plus (ii)” and all that follows through “clause (i) or (ii)” in subsection (a)(1)(A) and inserting in lieu thereof “plus (ii) the number of individuals, not counted under clause (i)”; and

(C) by striking out “(including expenditures” and all that follows through “the cost thereof)” in subsection (a)(2).

(2) Section 406 of such Act is amended— 42 USC 606.

(A) by striking out “, or (if provided” and all that follows through “under State law in behalf of,” and “or medical care or any type of remedial care recognized under State law” in subsection (b) in the matter preceding subparagraph (A), and

(B) by inserting “(for which such individual is not entitled to medical assistance under the State plan under title XIX)” in subsection (e)(1)(A) after “recognized under State law”.

(c)(1) Sections 1001 and 1401 of such Act are each amended by striking out “and of encouraging each State” and all that follows through “self-care”. 42 USC 1201, 1351.

(2) Sections 1003(a) and 1403(a) of such Act are each amended— 42 USC 1203, 1353.

(A) by striking out paragraph (1), and

(B) by striking out “(including expenditures for” and all that follows through “the cost thereof)” in paragraph (2).

(3) Sections 1006 and 1405 of such Act are each amended by striking out “, or (if provided” and all that follows through “under State law in behalf of,” in the matter before paragraph (1). 42 USC 1206, 1355.

(d)(1) The amendments made by this subsection are to the title XVI of the Social Security Act which only applies in the case of Puerto Rico, Guam, and the Virgin Islands under section 303(b) of the Social Security Amendments of 1972 (Public Law 92-603). 42 USC 1381.

(2) The heading of such title is amended by striking out “AND MEDICAL ASSISTANCE”. 42 USC 301 note.

(3) Section 1601 of such title is amended— 42 USC 1381.

(A) by striking out “(a)” the first place it appears in the first sentence,

(B) by striking out “, (b) of enabling” and all that follows through “or self-care” in the first sentence, and

(C) by striking out “, or for aid to the aged, blind, or disabled and medical assistance for the aged” in the second sentence.

(4) Section 1602 of such title is amended— 42 USC 1382.

(A) by striking out “, OR FOR SUCH AID AND MEDICAL ASSISTANCE FOR THE AGED” in the heading;

(B) by striking out “, or for aid to the aged, blind, or disabled and medical assistance for the aged” in subsection (a) in the matter before paragraph (1);

(C) by inserting “and” at the end of paragraph (13) of subsection (a);

(D) by striking out the semicolon at the end of paragraph (14) of subsection (a) and inserting in lieu thereof a period;

(E) by striking out paragraphs (15), (16), and (17) of subsection (a);

(F) by striking out “(or for aid to the aged, blind, or disabled and medical assistance for the aged)” in the second sentence of subsection (a);

(G) by striking out “(A) in the case of applicants for aid to the aged, blind, or disabled” in subsection (b)(2);

(H) by striking out “and (B)” and all that follows through “who resides in the State” in subsection (b)(2); and

(I) by striking out “(or for aid to the aged, blind, or disabled and medical assistance for the aged)” each place it appears in the third sentence of subsection (b).

42 USC 1383.

(5) Section 1603 of such title is amended—

(A) by striking out paragraphs (1) and (3) of subsection (a);

(B) by striking out “(including expenditures for premiums” and all that follows through “cost thereof)” in paragraph (2)(A);

(C) by striking out “the larger of the following amounts: (i)”, “(I)”, and “, or (II)” and all that follows before the semicolon, in paragraph (2)(B); and

(D) by striking out subsection (d).

42 USC 1385.

(6) Section 1605 of such title is amended—

(A) by striking out “, or (if provided)” and all that follows through “under State law in behalf of,” in subsection (a) in the matter before paragraph (1), and

(B) by striking out subsection (b).

Maternal and
Child Health
Services Block
Grant Act.

Subtitle D—Maternal and Child Health Services Block Grant

SHORT TITLE OF SUBTITLE

42 USC 1305.

SEC. 2191. This subtitle may be cited as the “Maternal and Child Health Services Block Grant Act”.

MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

SEC. 2192. (a) Title V of the Social Security Act is amended to read as follows:

“TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

“AUTHORIZATION OF APPROPRIATIONS

42 USC 701.

“SEC. 501. (a) For the purpose of enabling each State—

“(1) to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services,

“(2) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low income children, and prenatal, delivery, and postpartum care for low income mothers),

“(3) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI of this Act, and

42 USC 1381.

“(4) to provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for

diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling;

and for the purpose of enabling the Secretary to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and crippled children, for genetic disease testing, counseling, and information development and dissemination programs, and for grants relating to hemophilia (without regard to age), there are authorized to be appropriated \$373,000,000 for fiscal year 1982 and for each fiscal year thereafter.

“(b) For purposes of this title:

“(1) The term ‘consolidated health programs’ means the programs administered under the provisions of—

“(A) this title (relating to maternal and child health and crippled children’s services),

“(B) section 1615(c) of this Act (relating to supplemental security income for disabled children), 42 USC 1382d.

“(C) sections 316 (relating to lead-based paint poisoning prevention programs), 1101 (relating to genetic disease programs), 1121 (relating to sudden infant death syndrome programs) and 1131 (relating to hemophilia treatment centers) of the Public Health Service Act, and 42 USC 247a, 1301, 1320a, 1320b-1.

“(D) title IV of the Health Services and Centers Amendments of 1978 (Public Law 95-626; relating to adolescent pregnancy grants), 42 USC 247b-1.

as such provisions were in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act.

“(2) The term ‘low income’ means, with respect to an individual or family, such an individual or family with an income determined to be below the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 624 of the Economic Opportunity Act of 1964.

“Low income.”

42 USC 2971d.

“ALLOTMENTS TO STATES AND FEDERAL SET-ASIDE

“SEC. 502. (a)(1) Of the amount appropriated under section 501(a), the Secretary shall retain an amount equal to 15 percent thereof in the case of fiscal year 1982, and an amount equal to not less than 10, nor more than 15, percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional and national significance, training, and research and for the funding of genetic disease testing, counseling, and information development and dissemination programs and of comprehensive hemophilia diagnostic and treatment centers. The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts. 42 USC 702.

“(2) For purposes of paragraph (1)—

“(A) amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children; and

“(B) amounts retained by the Secretary for research shall be used to make grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit institutions of higher learning and public or nonprofit private agencies and organizations engaged in research or in maternal and child

health or crippled children's programs for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof.

"(3) No funds may be made available by the Secretary under this subsection unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this title.

"(b) From the remaining amounts appropriated under section 501(a) for any fiscal year, the Secretary shall allot to each State which has transmitted a description of intended activities and statement of assurances for the fiscal year under section 505, an amount determined as follows:

"(1) The Secretary shall determine, for each State—

"(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 501(b)(1)), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981,

"(ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and

"(B)(i) the number of low income children in the State, and

"(ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

"(2)(A) For each of fiscal years 1982 and 1983, each such State shall be allotted for that fiscal year an amount equal to the State's proportion (determined under paragraph (1)(A)(ii)) of the amounts available for allotment to all the States under this subsection for that fiscal year.

"(B) For fiscal years beginning with fiscal year 1984, if the amount available for allotment under this subsection for that fiscal year—

"(i) does not exceed the amount available under this subsection for allotment for fiscal year 1983, each such State shall be allotted for that fiscal year an amount equal to the State's proportion (determined under paragraph (1)(A)(ii)) of the amounts available for allotment to all the States under this subsection for that fiscal year, or

"(ii) exceeds the amounts available under this subsection for allotment for fiscal year 1983, each such State shall be allotted for that fiscal year an amount equal to the sum of—

"(I) the amount of the allotment to the State under this subsection in fiscal year 1983 (without regard to paragraph (3) of this subsection), and

"(II) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

“(3)(A) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505 for the fiscal year or because some States have indicated in their descriptions of activities under section 505 that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this subparagraph.

“(B) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this subparagraph.

“PAYMENTS TO STATES

“SEC. 503. (a) From the sums appropriated therefor and the allotments available under section 502(b), the Secretary shall make payments as provided by section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213) to each State provided such an allotment under section 502(b), for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title. 42 USC 703.

“(b) Any amount payable to a State under this title from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this title from allotments for a fiscal year for expenditures made after the following fiscal year.

“(c) The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

“(1) the fair market value of any supplies or equipment furnished the State, and

“(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section 505 on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

“USE OF ALLOTMENT FUNDS

“SEC. 504. (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its description of intended expenditures and statement of assurances transmitted under section 505. 42 USC 704.

“(b) Amounts described in subsection (a) may not be used for—

“(1) inpatient services, other than inpatient services provided to crippled children or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

“(2) cash payments to intended recipients of health services;

“(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

“(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

“(5) providing funds for research or training to any entity other than a public or nonprofit private entity.

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

“(c) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title.

“DESCRIPTION OF INTENDED EXPENDITURES AND STATEMENT OF ASSURANCES

42 USC 705.

“SEC. 505. In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary—

“(1) a report describing the intended use of payments the State is to receive under this title for the fiscal year, including (A) a description of those populations, areas, and localities in the State which the State has identified as needing maternal and child health services, (B) a statement of goals and objectives for meeting those needs, (C) information on the types of services to be provided and the categories or characteristics of individuals to be served, and (D) data the State intends to collect respecting activities conducted with such payments; and

“(2) a statement of assurances that represents to the Secretary that—

“(A) the State will provide a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;

“(B) funds allotted to the State under this title will only be used, consistent with section 508, to carry out the purposes of this title or to continue activities previously conducted under the consolidated health programs (described in section 502(b)(1));

“(C) the State will use—

“(i) a substantial proportion of the sums expended by the State for carrying out this title for the provision of health services to mothers and children, with special

consideration given (where appropriate) to the continuation of the funding of special projects in the State previously funded under this title (as in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act), and

“(ii) a reasonable proportion (based upon the State’s previous use of funds under this title) of such sums to carry out the purposes described in paragraphs (1) through (3) of section 501(a);

“(D) if the State imposes any charges for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services; and

“(E) the State agency (or agencies) administering the State’s program under this title will participate—

“(i) in the coordination of activities between such program and the early and periodic screening, diagnosis, and treatment program under title XIX, to ensure that such programs are carried out without duplication of effort,

“(ii) in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX), and

“(iii) in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs).

The description and statement shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and statement and after its transmittal. The description and statement shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in any element of such description or statement, and any revision shall be subject to the requirements of the preceding sentence.

“REPORTS AND AUDITS

“SEC. 506. (a)(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this title. In order properly to evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such form and contain such information as the Secretary determines (after consultation with the States and the Comptroller General) to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds, and of the progress made toward achieving the purposes of this title, and (C) to determine the extent to which funds were expended consistent with the State’s description and statement transmitted under section 505. Copies of the report shall be 42 USC 706.

provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

"(2) The Secretary shall annually report to the Congress on activities funded under section 502(a) and shall provide for transmittal of a copy of such report to each State.

"(b)(1) Each State shall, not less often than once every two years, audit its expenditures from amounts received under this title. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this title in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the State shall submit a copy of that audit report to the Secretary.

"(2) Each State shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this title and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the State is or may become entitled under this title or may otherwise recover such amounts.

"(3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any State which is not using its allotment under this title in accordance with this title. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

"(c) The State shall make copies of the reports and audits required by this section available for public inspection within the State.

"(d)(1) For the purpose of evaluating and reviewing the block grant established under this title, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

"(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

"(3) For other provisions relating to deposit, accounting, reports, and auditing with respect to Federal grants to States, see section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212).

"CRIMINAL PENALTY FOR FALSE STATEMENTS

"SEC. 507. (a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this title, or

"(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized,

shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

“(b) For civil monetary penalties for certain submissions of false claims, see section 1128A of this Act.

“NONDISCRIMINATION

“SEC. 508. (a)(1) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under title IX of the Education Amendments of 1972, or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964, programs and activities funded in whole or in part with funds made available under this title are considered to be programs and activities receiving Federal financial assistance. 42 USC 708.

“(2) No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

“(b) Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section 502(b), has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

“(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

“(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable, or

“(3) take such other action as may be provided by law.

“(c) When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

“ADMINISTRATION OF TITLE AND STATE PROGRAMS

“SEC. 509. (a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for— 42 USC 709.

“(1) the Federal program described in section 502(a);

“(2) promoting coordination at the Federal level of the activities authorized under this title and under title XIX of this Act, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;

"(3) disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;

"(4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation;

"(5) in cooperation with the National Center for Health Statistics and in a manner that avoids duplication of data collection, collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children in the United States; and

"(6) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections 505 and 506.

"(b) The State health agency of each State shall be responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under this title, except that, in the case of a State which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this title (as in effect on such date) by a State agency other than the State health agency, that State shall be considered to comply the requirement of this subsection if it would otherwise comply but for the fact that such other State agency administers (or supervises the administration of) any such program providing services for crippled children."

42 USC 706 note.

(b)(1) The Secretary of Health and Human Services shall, no later than October 1, 1984, report to the Congress on the activities of States receiving allotments under title V of the Social Security Act (as amended by this section) and include in such report any recommendations for appropriate changes in legislation.

(2) The Secretary of Health and Human Services, in consultation with the Comptroller General, shall examine alternative formulas, for the allotment of funds to States under section 502(b) of the Social Security Act (as amended by this section) which might be used as a substitute for the method of allotting funds described in such section, which provide for the equitable distribution of such funds to States (as defined for purposes of such section), and which take into account—

(A) the populations of the States,

(B) the number of live births in the States,

(C) the number of crippled children in the States,

(D) the number of low income mothers and children in the States,

(E) the financial resources of the various States, and

(F) such other factors as the Secretary deems appropriate, and shall report to the Congress thereon not later than June 30, 1982.

REPEALS AND CONFORMING AMENDMENTS

42 USC 247a.

SEC. 2193. (a)(1)(A) Section 316(g) of the Public Health Service Act is amended by inserting "and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$8,300,000 for the fiscal year ending September 30, 1982" before the period.

42 USC 300b.

(B) Section 1101(b) of such Act is amended by inserting "and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$9,680,000 for the fiscal year ending September 30, 1982" before the period.

Post, p. 828.

(C) Section 1121(d)(1) of such Act is amended by inserting “; and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$2,075,000 for fiscal year 1982” before the period. 42 USC 300c-11.
Post, p. 828.

(D) Section 1131(f) of such Act is amended by inserting “, and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$2,765,000 for the fiscal year ending September 30, 1982” before the period. 42 USC 300c-21.

(2) Section 607 of the Health Services and Centers Amendments of 1978 (Public Law 95-626) is amended by inserting “, and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$8,530,000 for the fiscal year ending September 30, 1982” before the period. 42 USC 300a-27.

(3) Section 501 of the Social Security Act (as in effect before the date the amendment made by section 2192(a) becomes effective) is amended by striking out “for each fiscal year thereafter” and inserting in lieu thereof “and for each of the next three fiscal years, and, subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act, \$317,580,000 for the fiscal year ending September 30, 1982”. 42 USC 701.

(4)(A) Section 1615(e)(1) of the Social Security Act is amended by inserting “and subject to section 2194(b)(3) of the Maternal and Child Health Services Block Grant Act” after “paragraphs (2) and (3)”. 42 USC 1382d.

(B) Effective for fiscal year 1982, section 1615(e)(3) of such Act is amended by striking out “\$30,000,000” and inserting in lieu thereof “\$24,070,000”.

(b)(1) Sections 316, 1101, 1121 and 1131 of the Public Health Service Act are repealed.

(2) Section 1104(a) of such Act is amended by inserting “and” at the end of paragraph (3), by striking out paragraph (4), and by redesignating paragraph (5) as paragraph (4). 42 USC 247a, 300b, 300c-11, 300c-21.
42 USC 300b-3.

(3) Section 1104 of such Act is further amended (A) by striking out subsections (b) and (d), (B) by striking out “or under section 1101” in subsection (c), and (C) by redesignating subsection (c) as subsection (b).

(4) Sections 1106 and 227 of such Act are repealed.

(5) Section 1107 of such Act is amended by striking out “appropriated under section 1101(b)” and inserting in lieu thereof “allotted for use under section 502(a) of the Social Security Act”. 42 USC 300b-5, 236.
42 USC 300b-6.

(c)(1) Section 1108(d) of the Social Security Act is amended by striking out “section 502(a)” and all that follows through “1967” and inserting in lieu thereof “section 421”. 42 USC 1308.

(2) Section 1101(a)(9)(D) of such Act is amended by striking out “V, XVIII, and XIX” and inserting in lieu thereof “XVIII and XIX”. 42 USC 1301.

(3) Section 1122 of such Act is amended— 42 USC 1320a-1.

(A) by striking out “V, XVIII, and XIX” and inserting in lieu thereof “XVIII and XIX” each place it appears, and

(B) by striking out “V, XVIII, or X” in subsection (d)(2) and inserting in lieu thereof “XVIII or XIX”.

(4) Section 1129 of such Act is amended— 42 USC 1320a-8.

(A) by striking out “V or” each place it appears in subsection (a), and

(B) by striking out “V, XVIII, or” in subsection (b)(2) and inserting in lieu thereof “XVIII or”.

(5) Section 1132(a)(1) of such Act is amended by striking out “V,”. 42 USC 1320b-2.

(6) Section 1134 of such Act is amended by striking out “V, XVIII,” and inserting in lieu thereof “XVIII”. 42 USC 1320b-4.

(7) Section 1172(4) of such Act is amended by striking out “V,”. 42 USC 1320c-21.

42 USC 1382d.

(8)(A) Subsection (a) of section 1615 of such Act is amended by striking out "appropriate State agency administering the State plan under subsection (b) of this section, and (except in such cases" and inserting in lieu thereof "State agency administering the State program under title V, and (except for individuals who have not attained age 16 and except in such other cases".

Ante, p. 818.

42 USC 1395x.

42 USC 1396a.

(B) Subsections (b) and (e) of such section are repealed.

(9) Section 1861(w)(2) of such Act is amended by striking out "V or".

(9) Section 1902(a)(11)(B) of such Act is amended—

(A) by striking out "for part or all of the cost of plans or projects under" and inserting in lieu thereof "under (or through an allotment under)", and

(B) by striking out "such plan or project under title V" and inserting in lieu thereof "such title or allotment".

42 USC 1395b-1.

(d)(1) The second sentence of section 402(a)(1) of the Social Security Amendments of 1967 (P.L. 90-248) is amended—

(A) by striking out "title XVIII of such Act," and inserting in lieu thereof "title XVIII of such Act and", and

(B) by striking out the ", and a program established by a plan of a State approved under title V of such Act".

(2) Section 402(a)(2) of such Act is amended by striking out "titles V and XIX" and inserting in lieu thereof "title XIX" both places it occurs.

(3) Section 402(b) of such Act is amended by striking out ", XIX, and V" and inserting in lieu thereof "and XIX".

42 USC 1395b-1
note.

(e)(1) Section 222(a)(1) of the Social Security Amendments of 1972 (P.L. 92-603) is amended by striking out "titles XIX and V" and inserting in lieu thereof "title XIX".

(2) The first sentence of section 222(a)(3) of such Act is amended by striking out ", XIX, and V" and inserting in lieu thereof "and XIX".

(3) Section 222(a)(4) of such Act is amended by striking out "titles V and XIX" and inserting in lieu thereof "title XIX" both places it appears.

42 USC 300a-21,
300a-41.

(f) Titles VI and VII of the Health Services and Centers Amendments of 1978 (P.L. 95-626) are repealed.

42 USC 1320a-8
note.

(g) Section 914(d) of the Omnibus Reconciliation Act of 1980 (P.L. 96-499; 94 Stat. 2622) is amended by striking out "V, XVIII," and inserting in lieu thereof "XVIII".

EFFECTIVE DATE; TRANSITION

42 USC 701 note.

SEC. 2194. (a) Except as otherwise provided in this section, the amendments made by sections 2192 and 2193 of this subtitle do not apply to any grant made, or contract entered into, or amounts payable to States under State plans before the earlier of—

(1) October 1, 1982, or

(2)(A) in the case of such grants, contracts, or payments under consolidated State programs (as defined in subsection (c)(2)(C)) to a State (or entities in the State), the date the State is first entitled to an allotment under title V of the Social Security Act (as amended by this subtitle), or

(B) in the case of grants and contracts under consolidated Federal programs (as defined in subsection (c)(2)(B)), October 1, 1981, or such later date (before October 1, 1982) as the Secretary determines to be appropriate.

(b)(1) The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") may not provide for any allotment to a State under title V of the Social Security Act (as

amended by this subtitle) for a calendar quarter in fiscal year 1982 unless the State has notified the Secretary, at least 30 days (or 15 days in the case of the first calendar quarter of the fiscal year) before the beginning of the calendar quarter, that the State requests an allotment for that calendar quarter (and subsequent calendar quarters).

(2)(A) Any grants or contracts entered into under the authorities of the consolidated State programs (as defined in subsection (c)(2)(C)) after the date of the enactment of this subtitle shall permit the termination of such grant or contract upon three months notice by the State in which the grantee or contractor is located.

(B) The Secretary shall not make or renew any grants or contracts under the provisions of the consolidated State programs (as defined in subsection (c)(2)(C)) to a State (or an entity in the State) after the date the State becomes entitled to an allotment of funds under title V of the Social Security Act (as amended by this subtitle).

(3)(A) In the case of funds appropriated for fiscal year 1982 for consolidated health programs (as defined in subsection (c)(2)(A)), such funds shall (notwithstanding any other provision of law) be available for use under title V of the Social Security Act (as amended by this subtitle), subject to subparagraphs (B) and (C).

(B) Notwithstanding any other provision of law—

(i) the amount that may be made available for expenditures for the consolidated Federal programs for fiscal year 1982 and for projects and programs under section 502(a) of the Social Security Act (as amended by this subtitle) may not exceed the amount provided for projects and programs under such section 502(a) for that fiscal year, and

(ii) the amount that may be made available to a State (or entities in the State) for carrying out the consolidated State programs for fiscal year 1982 and for allotments to the State under section 502(b) of the Social Security Act (as amended by this subtitle) may not exceed the amount which is allotted to the State for that fiscal year under such section (without regard to paragraphs (3) and (4) thereof).

(C) For fiscal year 1982, the Secretary shall reduce the amount which would otherwise be available—

(i) for expenditures by the Secretary under section 502(a) of the Social Security Act (as amended by this subtitle) by the amounts which the Secretary determines or estimates are payable for consolidated Federal programs (as defined in subsection (c)(2)(B)) from funds for fiscal year 1982, and

(ii) for allotment to each of the States under section 502(b) of such Act (as so amended) by the amounts which the Secretary determines or estimates are payable to that State (or entities in the State) under the consolidated State programs (as defined in subsection (c)(2)(C)) from funds for fiscal year 1982.

(c) For purposes of this section:

Definitions.

(1) The term "State" has the meaning given such term for purposes of title V of the Social Security Act.

(2)(A) The term "consolidated health programs" has the meaning given such term in section 501(b) of the Social Security Act (as amended by this subtitle).

(B) The term "consolidated Federal programs" means the consolidated health programs—

(i) of special projects grants under sections 503 and 504, and training grants under section 511, of the Social Security Act,

42 USC 300b.

42 USC 300c-21.

Ante, p. 762.

Ante, p. 764.

42 USC 706.

(ii) of grants and contracts for genetic disease projects and programs under section 1101 of the Public Health Service Act, and

(iii) of grants or contracts for comprehensive hemophilia diagnostic and treatment centers under section 1131 of the Public Health Service Act,

as such sections are in effect before the date of the enactment of this subtitle.

(C) The term “consolidated State programs” means the consolidated health programs, other than the consolidated Federal programs.

(d) The provisions of chapter 2 of subtitle C of title XVII of this Act shall not apply to this subtitle (or the programs under the amendments made by this title) and, specifically, section 1745 of this Act shall not apply to financial and compliance audits conducted under section 506(b) of the Social Security Act (as amended by this subtitle).

TITLE XXII—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

TABLE OF CONTENTS OF TITLE

- Sec. 2201. Repeal of minimum benefit provisions.
- Sec. 2202. Restrictions on the lump-sum death payment.
- Sec. 2203. Payment of certain benefits only for months after month in which entitlement conditions are fulfilled.
- Sec. 2204. Temporary extension of earnings limitation to include all persons aged less than seventy-two.
- Sec. 2205. Termination of mother’s and father’s benefits when child attains age sixteen.
- Sec. 2206. Rounding of benefits.
- Sec. 2207. Requests for information; cost reimbursement.
- Sec. 2208. Reduction in disability benefits on account of other related payments; extension of offset to disabled worker beneficiaries aged 62 through 64 and their families; change in month in which payments are offset.
- Sec. 2209. Reimbursement of States for successful rehabilitation services.
- Sec. 2210. Elimination of child’s insurance benefits in the case of children aged 18 through 22 who attend postsecondary schools.

REPEAL OF MINIMUM BENEFIT PROVISIONS

42 USC 415.

SEC. 2201. (a) Section 215(a)(1)(C)(i) of the Social Security Act is amended to read as follows:

“(C)(i) No primary insurance amount computed under subparagraph (A) may be less than an amount equal to \$11.50 multiplied by the individual’s years of coverage in excess of 10, or the increased amount determined for purposes of this clause under subsection (i).”.

(b)(1) Section 215(a)(1)(C)(ii) of such Act is amended by striking out “For purposes of clause (i)(II)” and inserting in lieu thereof “For purposes of clause (i)”.

(2) Section 215(a)(3)(A) of such Act is amended by striking out “subparagraph (C)(i)(II)” and inserting in lieu thereof “subparagraph (C)(i)”.

(3) Section 215(a)(4) of such Act is amended—

(A) by striking out “subparagraph (C)(i)(II)” and inserting in lieu thereof “subparagraph (C)(i)”; and

(B) in subclause (I) thereof, by striking out “but without regard to clauses (iv) and (v) thereof”.

(4) Section 215(f)(8) of such Act is amended by striking out “subsection (a)(1)(C)(i)(II)” and inserting in lieu thereof “subsection (a)(1)(C)(i)”. 42 USC 415.

(5) Section 215(i)(2)(A)(ii)(II) of such Act is amended by striking out “(including a primary insurance amount determined under subsection (a)(1)(C)(i)(I), but subject to the provisions of such subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph)”.

(6) Section 215(i)(2)(A)(ii) of such Act is amended in the matter following subclause (III) by striking out “subparagraph (C)(i)(II)” and inserting in lieu thereof “subparagraph (C)(i)”.

(7) Section 215(i)(2)(A)(iii) of such Act is amended by striking out “and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph”.

(8) Section 215(i)(2)(A) of such Act is amended by striking out clauses (iv) and (v) thereof.

(9) Section 215(i)(2)(D) of such Act is amended by striking out “subparagraph (C)(i)(II)” each place it appears and inserting in lieu thereof in each instance “subparagraph (C)(i)”.

(10) Section 202(m) of such Act is repealed. 42 USC 402.

(11) Paragraphs (1) and (5) of section 202(w) of such Act are each amended by striking out “section 215(a)(1)(C)(i)(II)” and inserting in lieu thereof in each instance “section 215(a)(1)(C)(i)”.

(12) Section 233(c)(2) of such Act is amended to read as follows: 42 USC 433.

“(2) Any such agreement may provide that an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement.”.

(c)(1) Section 215(a) of such Act is amended by adding at the end thereof the following new paragraph: 42 USC 415.

“(6)(A) The table of benefits in effect in December 1978 under this section, referred to in paragraph (4) in the matter following subparagraph (B) and in paragraph (5), revised as provided by subsection (i), as applicable, shall be extended for average monthly wages of less than \$76.00 and primary insurance benefits (as determined under subsection (d)) of less than \$16.20.

“(B) The Secretary shall determine and promulgate in regulations the methodology for extending the table under subparagraph (A).”.

(2) Section 215(a)(4) of such Act is amended, in the matter following subparagraph (B), by inserting “, as modified by paragraph (6),” after “table of benefits in effect in December 1978”.

(3) Section 215(a)(5) of such Act is amended—

(A) by inserting before the period at the end of the first sentence the following: “, and the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be modified as specified in paragraph (6)”;

(B) in the last sentence by inserting “, modified by the application of paragraph (6),” after “December 1978”.

(4) Section 215(f)(7) of such Act is amended by adding at the end thereof the following new sentence: “The recomputation shall be modified by the application of section 215(a)(6), where applicable.”.

(5) Section 215(i)(4) of such Act is amended by inserting “, modified by the application of subsection (a)(6),” after “December 1978” each place it appears.

(6) Section 203(a)(8) of such Act is amended by inserting “, modified by the application of section 215(a)(6)” before “, except that”. 42 USC 403.

42 USC 417.

(7) Section 217(b)(1) of such Act is amended by inserting before the period at the end of the first sentence the following: “, and as modified by the application of section 215(a)(6)”.

42 USC 402.

(d)(1) Section 202(q)(4) of such Act is amended by striking out “increased” and “increase” each place they appear and inserting in lieu thereof “changed” and “change”, respectively.

(2) Section 202(q)(10) of such Act is amended in the matter preceding subparagraph (A) by striking out “increased”, “increase”, and “increases” each place they appear and inserting in lieu thereof “changed”, “change”, and “changes”, respectively.

Primary
insurance
amounts,
recalculation.
42 USC 415 note.
42 USC 415.

(e)(1) The Secretary of Health and Human Services shall recalculate the primary insurance amounts applicable to—

(A) beneficiaries whose benefits are based on a primary insurance amount that was computed under section 215(a)(1)(C)(i)(I) of the Social Security Act, and

(B) beneficiaries with average monthly wages of less than \$76.00 and primary insurance benefits of less than \$16.20 whose benefits are based on primary insurance amounts computed under section 215(a)(4) or section 215(a)(5) of such Act.

(2) In the case of individuals to whom sections 215(a)(1) and 215(a)(4) of such Act as in effect after December 1978 do not apply, the Secretary shall recalculate the primary insurance amount computed under section 215 as in effect in December 1978 as though the individual had first become entitled in December 1978; except that—

(A) the table in, or deemed to be in, the law as the result of the amendments made by subsection (c)(1) of this section shall be used in lieu of the table in effect in December 1978;

(B) in the case of individuals who were born after January 1, 1913, the first sentence of section 215(b)(3) of the law as so in effect shall be deemed to read: “For purposes of paragraph (2), the number of an individual’s elapsed years is the number of calendar years after 1950 (or, if later, after the year of attainment of age 21) and before 1961 or, if later, the earlier of the year in which such individual died or attained age 62.”;

(C) in the case of individuals who were born prior to January 2, 1913, the first sentence of section 215(b)(3) of the law as so in effect shall be deemed to read: “For purposes of paragraph (2), the number of an individual’s elapsed years is the number of calendar years after 1950 and before 1961 or, if later, the earlier of the year in which such individual died or attained, in the case of a man (except as provided by section 104(j) of Public Law 92-603) age 65, or in the case of a woman, age 62.”;

42 USC 414 note.

(D) section 215(b)(4) of the law as so in effect shall be disregarded;

(E) section 215(d)(2)(C) of the law as so in effect shall be disregarded;

(F) section 215(d)(4) of the law as so in effect shall be deemed, for purposes of such recalculation, to read:

“(4) The provisions of this subsection as in effect in December 1977 (but without regard to paragraph (2)(C)) shall be applicable to individuals who became eligible for old-age or disability insurance benefits or died prior to 1978.”;

(G) in the case of individuals who became disabled, died, or attained age 65 prior to 1951, the Secretary shall by regulations provide an alternative computation in lieu of the computation provided by the law as so in effect (and modified by this paragraph); and

(H) in no event may the recalculated primary insurance amount exceed the primary insurance amount that is based on an average monthly wage of \$76.00 or the primary insurance amount that is based on a primary insurance benefit of \$16.20.

(3) In the case of individuals to whom either section 215(a) (1) or (4) of such Act apply, the primary insurance amount shall be recalculated under section 215 as in effect after December 1978; except that the table in or deemed to be in the law as a result of the amendments made by subsection (c)(1) of this section shall be used (where appropriate) in lieu of the table in effect in December 1978.

42 USC 415.

(f) The first sentence of section 202(i) of such Act is amended by inserting after "primary insurance amount" the following: "(as determined without regard to the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981, relating to the repeal of the minimum benefit provisions)".

Post, p. 834.

(g) Part A of title XVI of the Social Security Act is amended by adding at the end thereof the following new section:

Ante, p. 830.

**"BENEFITS FOR INDIVIDUALS FORMERLY RECEIVING MINIMUM BENEFITS
UNDER TITLE II**

"SEC. 1622. (a) Any individual who—

42 USC 1382k.

"(1) is 60 years of age or older but has not attained the age of 65;

"(2) would be an eligible individual or eligible spouse under section 1611 if such individual were 65 years of age;

42 USC 1382.

"(3) is not otherwise eligible for a benefit under section 1611;

"(4) for the month of February 1982 was entitled to a monthly benefit under title II of this Act for which he made application prior to March 1, 1982, as determined without regard to any deductions on account of work required by section 203, which entitlement amount (as so determined) was reduced for any month by reason of the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981 (relating to the repeal of the minimum benefit provisions); and

42 USC 401.

42 USC 403.

"(5) is not entitled under title II to a monthly benefit, as determined without regard to any deductions on account of work required by section 203, in an amount equal to or greater than such entitlement amount (as so determined) for February 1982; shall be eligible for a benefit for each month in which he meets the requirements of this subsection in an amount determined under subsection (b) or (c).

"(b) The amount of the monthly benefit payable under subsection (a) shall be the amount of the monthly benefit which would otherwise be payable to such individual under this title if he were 65 years of age; except that—

"(1) the amount of such monthly benefit shall not exceed—

"(A) in the case of an individual described in subsection (a) who does not have an eligible spouse, an amount equal to the amount by which such individual's monthly benefit entitlement under title II for such month as determined without regard to any deductions on account of work required by section 203, is less than the amount of such individual's monthly benefit entitlement under title II for February 1982 (as so determined); or

"(B) in the case of an individual and his spouse, both of whom are individuals described in subsection (a), an amount equal to the amount by which the combined amount of their monthly benefit entitlements under title II for such month

(as so determined), is less than the combined amount of their monthly benefit entitlements under title II for February 1982 (as so determined);

“(2) the benefit amount shall be determined on the basis of the dollar amounts applicable under this title for February 1982 (without regard to cost-of-living adjustments made after February 1982 under section 1617) in the case of any individuals described in paragraph (1); and

“(3) in the case of an individual described in subsection (a) who has a spouse eligible for benefits under this title, other than by reason of this section, the amount of such monthly benefit for such individual (described in subsection (a)) shall be determined under subsection (c), and the amount of the monthly benefit for such spouse shall be determined in the same manner as for an individual who does not have an eligible spouse.

“(c) The amount of the monthly benefit for an individual described in subsection (b)(3) shall be an amount equal to the amount by which—

“(1) the monthly benefit amount for which such individual and his spouse would be eligible for such month under this title if both he and his spouse were 65 years of age, determined on the basis of the dollar amounts applicable under this title for February 1982 (without regard to cost-of-living adjustments made after February 1982 under section 1617); exceeds

“(2) the monthly benefit amount under this title for which his spouse is eligible for such month;

except that the amount of such monthly benefit shall not exceed the amount by which such individual's monthly benefit entitlement under title II for such month, as determined without regard to deductions on account of work under section 203, is less than his monthly benefit entitlement under title II (as so determined) for February 1982.

“(d) An individual who is entitled to a benefit under this section shall not be considered to be an individual receiving supplemental security income benefits under this title for purposes of section 1616 of this title or of any provision of law other than this title.”.

(h)(1) This section and the amendments made thereby shall be effective with respect to—

(A) benefits payable for months after October 1981 in the case of individuals who initially become eligible for benefits under title II of the Social Security Act after October 1981; and

(B) benefits payable for months after February 1982 in the case of all other individuals.

(2) For purposes of this subsection, eligibility shall be determined in accordance with paragraphs (2)(A) and (3)(B) of section 215(a) of the Social Security Act.

RESTRICTIONS ON THE LUMP-SUM DEATH PAYMENT

SEC. 2202. (a)(1) Section 202(i) of the Social Security Act is amended—

(A) in the second sentence, by striking out paragraphs (1), (2), (3), and (4) and inserting in lieu thereof the following:

“(1) to a widow (as defined in section 216(c)) or widower (as defined in section 216(g)) who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to

benefits under subsection (e), (f), or (g) of this section for the month in which occurred such individual's death; or

"(2) if no person qualifies for payment under paragraph (1), or if such person dies before receiving payment, in equal shares to each person who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (d) of this section for the month in which occurred such individual's death."; and

(B) in the third sentence, by striking out "(except a payment as authorized pursuant to clause (1)(A) of the preceding sentence)".

(2)(A) Section 216(c) of such Act is amended by inserting "the first sentence of" before "section 202(i)".

42 USC 416.

(B) Section 216(g) of such Act is amended by inserting "the first sentence of" before "section 202(i)".

(b) The amendments made by subsection (a) shall apply only with respect to deaths occurring after August 1981.

Effective date.
42 USC 402 note.

PAYMENT OF CERTAIN BENEFITS ONLY FOR MONTHS AFTER MONTH IN WHICH ENTITLEMENT CONDITIONS ARE FULFILLED

SEC. 2203. (a) Section 202(a) of the Social Security Act is amended by striking out so much of the first sentence as follows paragraph (3) and inserting in lieu thereof the following:

42 USC 402.

"shall be entitled to an old-age insurance benefit for each month, beginning with—

"(A) in the case of an individual who has attained age 65, the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or

"(B) in the case of an individual who has attained age 62, but has not attained age 65, the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)), and ending with the month preceding the month in which he dies.".

(b)(1) Section 202(b)(1) of such Act is amended by striking out the matter that follows subparagraph (D) and precedes subparagraph (E) and inserting in lieu thereof the following:

"shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with—

"(i) in the case of a wife or divorced wife (as so defined) of an individual entitled to old-age benefits, if such wife or divorced wife has attained age 65, the first month in which she meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

"(ii) in the case of a wife or divorced wife (as so defined) of—

"(I) an individual entitled to old-age insurance benefits, if such wife or divorced wife has not attained age 65, or

"(II) an individual entitled to disability insurance benefits, the first month throughout which she is such a wife or divorced wife and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month she meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs—".

(2) Section 216(b) of such Act is amended by adding at the end thereof the following new sentences: "For purposes of clause (2), a wife shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of her marriage to such individual. For purposes of

42 USC 416.

42 USC 402.

subparagraph (C) of section 202(b)(1), a divorced wife shall be deemed not to be married throughout the month in which she becomes divorced.”.

(c)(1) Section 202(c)(1) of such Act is amended by striking out the matter that follows subparagraph (C) and precedes the colon and inserting in lieu thereof the following:

“shall be entitled to a husband’s insurance benefit for each month, beginning with—

“(i) in the case of a husband (as so defined) of an individual who is entitled to an old-age insurance benefit, if such husband has attained age 65, the first month in which he meets the criteria specified in subparagraphs (A), (B), and (C), or

“(ii) in the case of a husband (as so defined) of—

“(I) an individual entitled to old-age insurance benefits, if such husband has not attained age 65, or

“(II) an individual entitled to disability benefits, the first month throughout which he is such a husband and meets the criteria specified in subparagraphs (B) and (C) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs”.

42 USC 416.

(2) Section 216(f) of such Act is amended by adding at the end thereof the following new sentence: “For purposes of clause (2), a husband shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of his marriage to her.”.

42 USC 402.

(d)(1) Section 202(d)(1) of such Act is amended by striking out so much of the first sentence as follows subparagraph (C) and precedes subparagraph (D) and inserting in lieu thereof the following:

“shall be entitled to a child’s insurance benefit for each month, beginning with—

“(i) in the case of a child (as so defined) of such an individual who has died, the first month in which such child meets the criteria specified in subparagraphs (A), (B), and (C), or

“(ii) in the case of a child (as so defined) of an individual entitled to an old-age insurance benefit or to a disability insurance benefit, the first month throughout which such child is a child (as so defined) and meets the criteria specified in paragraphs (B) and (C) (if in such month he meets the criterion specified in paragraph (A)),

whichever is earlier, and ending with the month preceding whichever of the following first occurs—”.

(2) Section 202(d)(7) of such Act is amended by adding at the end of subparagraph (A) the following new sentence: “An individual who is determined to be a full-time elementary or secondary school student shall be deemed to be such a student throughout the month with respect to which such determination is made.”.

42 USC 416.

(3) Section 216(e) of such Act is amended by adding at the end thereof the following new sentences: “For purposes of clause (2), a child shall be deemed to have been the stepchild of an individual for a period of one year throughout the month in which occurs the expiration of such one year. For purposes of clause (3), a person shall be deemed to have no natural or adoptive parent living (other than a parent who was under a disability) throughout the most recent month in which a natural or adoptive parent (not under a disability) dies.”.

(4) Section 216(h) of such Act is amended by adding at the end of paragraph (3) the following new sentence: "For purposes of subparagraph (A)(i), an acknowledgement, court decree, or court order shall be deemed to have occurred on the first day of the month in which it actually occurred." 42 USC 416.

(e) Section 226(a)(2) of such Act is amended—

(1) by striking out "or" after "section 202,"; and

94 Stat. 2263.

42 USC 426.

(2) by inserting, immediately after "therefor" the following: ", or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month,".

(f)(1) The amendments made by subsections (a), (b), and (c) of this section shall apply only to monthly insurance benefits payable to individuals who attain age 62 after August 1981. Effective dates. 42 USC 402 note.

(2) The amendments made by subsection (d) of this section shall apply to monthly insurance benefits for months after August 1981, and only in the case of individuals who were not entitled to such insurance benefits for August 1981 or any preceding month.

(3) The amendments made by subsection (e) of this section shall apply only to individuals aged 65 and over whose insured spouse attains age 62 after August 1982. 42 USC 426 note.

TEMPORARY EXTENSION OF EARNINGS LIMITATION TO INCLUDE ALL PERSONS AGED LESS THAN SEVENTY-TWO

SEC. 2204. (a) Notwithstanding subsection (e) of section 302 of the Social Security Amendments of 1977 (91 Stat. 1531; Public Law 95-216), the amendments made to section 203 of the Social Security Act by subsections (a) through (d) of such section 302 shall, except as provided in subsection (b) of this section, apply only with respect to monthly insurance benefits payable under title II of the Social Security Act for months after December 1982. 42 USC 403 note. 42 USC 403 note. 42 USC 403. 42 USC 401.

(b) In the case of any individual whose first taxable year (as in effect on the date of the enactment of this Act) ending after December 31, 1981, begins before January 1, 1982, the amendments made by section 302 of the Social Security Amendments of 1977 shall apply with respect to taxable years beginning with such taxable year.

TERMINATION OF MOTHER'S AND FATHER'S BENEFITS WHEN CHILD ATTAINS AGE SIXTEEN

SEC. 2205. (a)(1) Section 202(s)(1) of the Social Security Act is amended by striking out "the age of 18" and inserting in lieu thereof "the age of 16". 42 USC 402.

(2) The heading of section 202(s) of such Act is amended by striking out "Child Aged 18 or Over Attending School" and inserting in lieu thereof "Child Over Specified Age to be Disregarded for Certain Benefit Purposes Unless Disabled".

(b) The amendments made by subsection (a) shall apply with respect to wife's and mother's insurance benefits for months after the month in which this Act is enacted; except that, in the case of an individual who is entitled to such a benefit (on the basis of having a child in her care) for the month in which this Act is enacted, such amendments shall not take effect until the first day of the first month which begins 2 years or more after the date of the enactment of this Act. Effective date. 42 USC 402 note.

ROUNDING OF BENEFITS

42 USC 415.

SEC. 2206. (a) The text of section 215(g) of the Social Security Act is amended to read as follows:

42 USC 402, 423,
403, 424a.

42 USC 1395s.

“(g) The amount of any monthly benefit computed under section 202 or 223 which (after any reduction under sections 203(a) and 224 and any deduction under section 203(b), and after any deduction under section 1840(a)(1)) is not a multiple of \$1 shall be rounded to the next lower multiple of \$1.”.

42 USC 402.

(b)(1) Section 202(q)(8) of such Act is amended—

(A) in the first sentence, by striking out “after application of section 215(g)” and inserting in lieu thereof “before application of section 215(g)”; and

(B) in the last sentence, by striking out “reduced to the next lower” and inserting in lieu thereof “increased to the next higher”.

42 USC 403.

(2) Section 203(a)(1) of such Act is amended in the last sentence by striking out “increased to the next higher” and inserting in lieu thereof “decreased to the next lower”.

(3) Section 203(a)(3)(B)(iii) of such Act is amended in the parenthetical phrase immediately preceding the semicolon at the end thereof by striking out “higher” and inserting in lieu thereof “lower”.

(4) Section 203(a)(8) of such Act is amended by inserting at the end the following new sentence: “For purposes of the preceding sentence, the phrase ‘rounded to the next higher multiple of \$0.10’, as it appeared in subsection (a)(2)(C) of this section as in effect in December 1978, shall be deemed to read ‘rounded to the next lower multiple of \$0.10’”.

42 USC 415.

(5) Section 215(a)(1)(A) of such Act is amended by striking out “rounded in accordance with subsection (g),” and inserting in lieu thereof “rounded, if not a multiple of \$0.10, to the next lower multiple of \$0.10,”.

(6) Section 215(i)(2)(A)(ii) of such Act is amended in the sentence immediately following subclause (III) by striking out “increased to the next higher” and inserting in lieu thereof “decreased to the next lower”.

(7) Section 215(i)(4) of such Act is amended by inserting before the period at the end of the first sentence the following: “, except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase ‘increased to the next higher multiple of \$0.10’ shall be deemed to read ‘decreased to the next lower multiple of \$0.10’”.

Effective date.

42 USC 402 note.

(c) The amendments made by this section shall apply only with respect to initial calculations and adjustments of primary insurance amounts and benefit amounts which are attributable to periods after August 1981.

REQUESTS FOR INFORMATION; COST REIMBURSEMENT

42 USC 1306.

SEC. 2207. Section 1106 of the Social Security Act is amended—

(1) by striking out “as provided in part D of title IV of this Act” in the first sentence of subsection (a) and inserting in lieu thereof “as otherwise provided by Federal law”; and

(2) by inserting after subsection (b) the following new subsection:

“(c) Notwithstanding sections 552 and 552a of title 5, United States Code, or any other provision of law, whenever the Secretary determines that a request for information is made in order to assist a party

in interest (as defined in section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002)) with respect to the administration of an employee benefit plan (as so defined), or is made for any other purpose not directly related to the administration of the program or programs under this Act to which such information relates, the Secretary may require the requester to pay the full cost, as determined by the Secretary, of providing such information.”.

REDUCTION IN DISABILITY BENEFITS ON ACCOUNT OF OTHER RELATED PAYMENTS; EXTENSION OF OFFSET TO DISABLED WORKER BENEFICIARIES AGED 62 THROUGH 64 AND THEIR FAMILIES; CHANGE IN MONTH IN WHICH PAYMENTS ARE OFFSET

SEC. 2208. (a) Section 224 of the Social Security Act is amended— 42 USC 424a.

(1) in the caption, by striking out “ON ACCOUNT OF RECEIPT OF WORKMEN’S COMPENSATION”;

(2) in subsection (a), in the matter preceding paragraph (1), by striking out “age of 62” and inserting in lieu thereof “age of 65”;

(3) by amending subsection (a)(2) to read as follows:

“(2) such individual is entitled for such month to periodic benefits on account of such individual’s total or partial disability (whether or not permanent) under—

“(A) a workmen’s compensation law or plan of the United States or a State, or

“(B) any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section 218(k)), 42 USC 418.

other than benefits payable under title 38, United States Code, benefits payable under a program of assistance which is based on need, benefits based on service all, or substantially all, of which was included under an agreement entered into by a State and the Secretary under section 218, and benefits under a law or plan of the United States based on service all or part of which is employment as defined in section 210,”;

42 USC 410.

(4) in subsection (a)(4), by striking out “the workmen’s compensation law or plan” and inserting in lieu thereof “such laws or plans”;

(5) in subsection (b), by striking out “under a workmen’s compensation law or plan” and inserting in lieu thereof “for a total or partial disability under a law or plan described in subsection (a)(2)”;

(6) in subsection (d), by—

(A) striking out “workmen’s compensation law or plan” and inserting in lieu thereof “law or plan described in subsection (a)(2)”, and

(B) inserting before the period at the end thereof the following: “, and such law or plan so provided on February 18, 1981”;

(7) in subsection (e), by striking out “workmen’s compensation”; and

(8) by adding at the end thereof the following new subsection:

“(h)(1) Notwithstanding any other provision of law, the head of any Federal agency shall provide such information within its possession as the Secretary may require for purposes of making a timely determination of the amount of the reduction, if any, required by this section in benefits payable under this title, or verifying other information necessary in carrying out the provisions of this section.

“(2) The Secretary is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan subject to the provisions of this section, in order to obtain such information as he may require to carry out the provisions of this section.”.

Effective date.
42 USC 424a
note.
42 USC 423.

(b) The amendments made by subsection (a) shall be effective with respect to individuals who first become entitled to benefits under section 223(a) of the Social Security Act for months beginning after the month in which this Act is enacted, but only in the case of an individual who became disabled within the meaning of section 223(d) of such Act after the sixth month preceding the month in which this Act is enacted.

REIMBURSEMENT OF STATES FOR SUCCESSFUL REHABILITATION SERVICES

42 USC 422.

SEC. 2209. (a) Section 222(d) of the Social Security Act is amended to read as follows:

“Costs of Rehabilitation Services From Trust Funds

“(d)(1) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

42 USC 402.

“(A) entitled to disability insurance benefits under section 223,

“(B) entitled to child’s insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

“(C) entitled to widow’s insurance benefits under section 202(e) prior to attaining age 60, or

“(D) entitled to widower’s insurance benefits under section 202(f) prior to attaining age 60,

to the end that savings will accrue to the Trust Funds as a result of rehabilitating such individuals into substantial gainful activity, there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to enable the Secretary to reimburse the State for the reasonable and necessary costs of vocational rehabilitation services furnished such individuals (including services during their waiting periods), under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), which result in their performance of substantial gainful activity which lasts for a continuous period of nine months. The determination that the vocational rehabilitation services contributed to the successful return of such individuals to substantial gainful activity and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria formulated by him.

“(2) In the case of any State which is unwilling to participate or does not have a plan which meets the requirements of paragraph (1), the Commissioner of Social Security may provide such services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The provision of such services shall be subject to the same conditions as otherwise apply under paragraph (1).

Payments.

“(3) Payments under this subsection shall be made in advance or by way of reimbursement, with necessary adjustments for overpayments and underpayments.

“(4) Money paid from the Trust Funds under this subsection for the reimbursement of the costs of providing services to individuals who

are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

42 USC 423.

42 USC 402.

“(A) the total amount to be reimbursed for the cost of services under this subsection, and

“(B) subject to the provisions of the preceding sentence, the amount which should be charged to each of the Trust Funds.

“(5) For purposes of this subsection the term ‘vocational rehabilitation services’ shall have the meaning assigned to it in title I of the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purpose of this subsection.”

“Vocational rehabilitation services.”

(b) The amendment made by subsection (a) shall apply with respect to services rendered on or after October 1, 1981.

Effective date.
42 USC 422 note.

ELIMINATION OF CHILD'S INSURANCE BENEFITS IN THE CASE OF CHILDREN AGE 18 THROUGH 22 WHO ATTEND POSTSECONDARY SCHOOLS

SEC. 2210. (a)(1) Section 202(d) of the Social Security Act is amended in paragraphs (1)(B), (1)(E)(ii), (1)(F)(i), (1)(G)(III), (6)(D)(i), (6)(E)(i), (7)(A) (three places), (7)(B), and (7)(D), by striking out “full-time student” each place it appears and inserting in lieu thereof “full-time elementary or secondary school student”.

42 USC 402.

(2)(A) Section 202(d) of such Act is further amended in paragraphs (7)(A) (two places), (7)(B) (three places), and (7)(D), by striking out “educational institution” each place it appears and inserting in lieu thereof “elementary or secondary school”.

(B) Section 202(d)(7)(A) of such Act is further amended by striking out “institutions involved” and inserting in lieu thereof “schools involved”.

(3) Subparagraph (C) of section 202(d)(7) of such Act is amended to read as follows:

Definitions.

“(C)(i) An ‘elementary or secondary school’ is a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located.

“(ii) For the purpose of determining whether a child is a ‘full-time elementary or secondary school student’ or ‘intends to continue to be in full-time attendance at an elementary or secondary school’, within the meaning of this subsection, there shall be disregarded any education provided, or to be provided, beyond grade 12.”

(4) Section 202(d)(7)(D) of such Act is further amended by striking out “degree from a four-year college or university” and inserting in lieu thereof “diploma or equivalent certificate from a secondary school (as defined in subparagraph (C)(i))”.

(5)(A) Section 202(d) of such Act is further amended in paragraphs (1)(B)(i), (1)(F)(ii), (1)(G)(IV), (6)(D)(ii), (6)(E)(ii), and (7)(D) by striking out “22” each place it appears in each of those paragraphs and inserting in lieu thereof “19”.

(B) Section 202(d)(6)(A) of such Act is amended to read as follows:

42 USC 423.

Effective date.

42 USC 402 note.

42 USC 402.

42 USC 402 note.

“(A)(i) is a full-time elementary or secondary school student and has not attained the age of 19, or (ii) is under a disability (as defined in section 223(d)) and has not attained the age of 22, or”.

(b) Except as provided in subsection (c), the amendments made by subsection (a) shall apply to child's insurance benefits under section 202(d) of the Social Security Act for months after July 1982.

(c)(1) Notwithstanding the provisions of section 202(d) of the Social Security Act (as in effect prior to or after the amendments made by subsection (a)), any individual who—

(A) has attained the age of 18;

(B) is not under a disability (as defined in section 223(d) of such Act);

(C) is entitled to a child's insurance benefit under such section 202(d) for August 1981; and

(D) is a full-time student at a postsecondary school, college, or university that is an educational institution (as such terms are defined in section 202(d)(7) (A) and (C) of such Act as in effect prior to the amendments made by subsection (a)) for any month prior to May 1982;

shall be entitled to a child's benefit under section 202(d) of such Act in accordance with the provisions of such section as in effect prior to the amendments made by subsection (a) for any month after July 1981 and prior to August 1985 if such individual would be entitled to such child's benefit for such month under such section 202(d) if subsections (a) and (b) of this section had not been enacted, but such benefits shall be subject to the limitations set forth in this subsection.

(2) No benefit described in paragraph (1) shall be paid to an individual to whom paragraph (1) applies for the months of May, June, July, and August, beginning with benefits otherwise payable for May 1982.

(3) The amount of the monthly benefit payable under paragraph (1) to an individual to whom paragraph (1) applies for any month after July 1982 (prior to deductions on account of work required by section 203 of such Act) shall not exceed the amount of the benefit to which such individual was entitled for August 1981 (prior to deductions on account of work required by section 203 of such Act), less an amount—

(A) during the months after July 1982 and before August 1983, equal to 25 percent of such benefit for August 1981;

(B) during the months after July 1983 and before August 1984, equal to 50 percent of such benefit for August 1981; and

(C) during the months after July 1984 and before August 1985, equal to 75 percent of such benefit for August 1981.

(4) Any individual to whom the provisions of paragraph (1) apply and whose entitlement to benefits under paragraph (1) ends after July 1982 shall not subsequently become entitled, or reentitled, to benefits under paragraph (1) or under section 202(d) of the Social Security Act as in effect after the amendments made by subsection (a) unless he meets the requirements of section 202(d)(1)(B)(ii) of that Act as so in effect.

42 USC 403.

TITLE XXIII—PUBLIC ASSISTANCE PROGRAMS

Subtitle A—Aid to Families With Dependent Children; Child Support Enforcement

CHAPTER 1—AID TO FAMILIES WITH DEPENDENT CHILDREN

DISREGARDS FROM EARNED INCOME FOR AFDC

SEC. 2301. Section 402(a)(8) of the Social Security Act is amended to read as follows: 42 USC 602

“(8)(A) provide that, with respect to any month, in making the determination under paragraph (7), the State agency—

Post, p. 844.

“(i) shall disregard all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or a part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment;

“(ii) shall disregard from the earned income of any child or relative applying for or receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$75 of the total of such earned income for such month (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month);

“(iii) shall disregard from the earned income of any child, relative, or other individual specified in clause (ii), an amount equal to expenditures for care in such month for a dependent child, or an incapacitated individual living in the same home as the dependent child, receiving aid to families with dependent children and requiring such care for such month, to the extent that such amount (for each such dependent child or incapacitated individual) does not exceed \$160 (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month); and

“(iv) shall disregard from the earned income of any child or relative receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, an amount equal to the first \$30 of the total of such earned income not already disregarded under the preceding provisions of this paragraph plus one-third of the remainder thereof (but excluding, for purposes of this subparagraph, earned income derived from participation on a project maintained under the programs established by section 432(b)(2) and (3)); and

42 USC 632.

“(B) provide that (with respect to any month) the State agency—

"(i) shall not disregard, under clause (ii), (iii), or (iv) of subparagraph (A), any earned income of any one of the persons specified in subparagraph (A)(ii) if such person—

"(I) terminated his employment or reduced his earned income without good cause within such period (of not less than thirty days) preceding such month as may be prescribed by the Secretary;

"(II) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State or local agency administering the State plan, after notification by the employer, to be a bona fide offer of employment; or

"(III) failed without good cause to make a timely report (as prescribed by the State plan pursuant to paragraph (14)) to the State agency of earned income received in such month; and

"(ii)(I) shall not disregard, under subparagraph (A)(iv), any earned income of any of the persons specified in subparagraph (A)(ii), if, with respect to such month, the income of the persons so specified was in excess of their need, as determined by the State agency pursuant to paragraph (7) (without regard to subparagraph (A)(iv) of this paragraph), unless the persons received aid under the plan in one or more of the four months preceding such month and subparagraph (A)(iv) has not already been applied to their income for four consecutive months while they were receiving aid under the plan; and

"(II) in the case of the earned income of a person with respect to whom subparagraph (A)(iv) has been applied for four consecutive months, shall not apply the provisions of subparagraph (A)(iv) for so long as he continues to receive aid under the plan and shall not apply such provisions to any month thereafter until the expiration of an additional period of twelve consecutive months during which he is not a recipient of such aid;"

DETERMINATION OF INCOME AND RESOURCES FOR AFDC

SEC. 2302. Section 402(a)(7) of the Social Security Act is amended to read as follows:

"(7) except as may be otherwise provided in paragraph (8) or (31), provide that the State agency—

"(A) shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid;

"(B) shall determine ineligible for aid any family the combined value of whose resources (reduced by any obligations or debts with respect to such resources) exceeds \$1,000 or such lower amount as the State may determine, but not including as a resource for purposes of this subparagraph a

home owned and occupied by such child, relative, or other individual and so much of the family member's ownership interest in one automobile as does not exceed such amount as the Secretary may prescribe; and

"(C) may, in the case of a family claiming or receiving aid under this part for any month, take into consideration as income (to the extent the State determines appropriate, as specified in such plan, and notwithstanding any other provision of law)—

"(i) an amount not to exceed the value of the family's monthly allotment of food stamp coupons, to the extent such value duplicates the amount for food included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income; and

"(ii) an amount not to exceed the value of any rent or housing subsidy provided to such family, to the extent such value duplicates the amount for housing included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income;"

INCOME LIMIT FOR AFDC ELIGIBILITY

SEC. 2303. Section 402(a) of the Social Security Act is amended by inserting before paragraph (19) the following new paragraph: 42 USC 602.

"(18) provide that no family shall be eligible for aid under the plan for any month if, for that month, the total income of the family (other than payments under the plan), without application of paragraph (8), exceeds 150 percent of the State's standard of need for a family of the same composition;"

Ante. p. 843.

TREATMENT OF INCOME IN EXCESS OF THE STANDARD OF NEED; LUMP SUM PAYMENTS

SEC. 2304. Section 402(a) of the Social Security Act is amended by inserting after paragraph (16) the following new paragraph:

"(17) provide that if a person specified in paragraph (8)(A) (i) or (ii) receives in any month an amount of income which, together with all other income for that month not excluded under paragraph (8), exceeds the State's standard of need applicable to the family of which he is a member—

"(A) such amount of income shall be considered income to such individual in the month received, and the family of which such person is a member shall be ineligible for aid under the plan for the whole number of months that equals (i) the sum of such amount and all other income received in such month, not excluded under paragraph (8), divided by (ii) the standard of need applicable to such family, and

"(B) any income remaining (which amount is less than the applicable monthly standard) shall be treated as income received in the first month following the period of ineligibility specified in subparagraph (A);"

TREATMENT OF EARNED INCOME ADVANCE AMOUNT UNDER AFDC

SEC. 2305. Section 402(d)(1) of the Social Security Act is amended to read as follows:

“(1) For purposes of this part, an individual’s ‘income’ shall also include, to the extent and under the circumstances prescribed by the Secretary, an amount (which shall be treated as earned income for purposes of this part) equal to the earned income advance amount (under section 3507(a) of the Internal Revenue Code of 1954) that is (or, upon the filing of an earned income eligibility certificate, would be) payable to such individual.”.

26 USC 3507.

INCOME OF STEPPARENTS LIVING WITH DEPENDENT CHILD

42 USC 602.

SEC. 2306. (a) Section 402(a) of the Social Security Act is amended—

(1) by striking out “and” at the end of paragraph (29);

(2) by striking out the period at the end of paragraph (30) and inserting in lieu thereof “; and”; and

(3) by adding after paragraph (30) the following new paragraph:

Ante. p. 844.

“(31) provide that, in making the determination for any month under paragraph (7), the State agency shall take into consideration so much of the income of the dependent child’s stepparent living in the same home as such child as exceeds the sum of (A) the first \$75 of the total of such stepparent’s earned income for such month (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in fulltime employment or not employed throughout the month), (B) the State’s standard of need under such plan for a family of the same composition as the stepparent and those other individuals living in the same household as the dependent child and claimed by such stepparent as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making the determination under paragraph (7), (C) amounts paid by the stepparent to individuals not living in such household and claimed by him as dependents for purposes of determining his Federal personal income tax liability, and (D) payments by such stepparent of alimony or child support with respect to individuals not living in such household.”.

42 USC 612.

Supra.

(b) Section 412(b) of the Social Security Act is amended by striking out “does not include any such relative” and inserting in lieu thereof “does not include a stepparent whose income is taken into consideration under section 402(a)(31) (regardless of whether such income exceeds the sum specified in such section) or any other such relative”.

COMMUNITY WORK EXPERIENCE PROGRAMS

42 USC 609.

SEC. 2307. (a) Section 409 of the Social Security Act is amended to read as follows:

“COMMUNITY WORK EXPERIENCE PROGRAMS

“SEC. 409. (a)(1) Any State which chooses to do so may establish a community work experience program in accordance with this section. The purpose of the community work experience program is to provide experience and training for individuals not otherwise able to obtain employment, in order to assist them to move into regular employment. Community work experience programs shall be designed to improve the employability of participants through actual work experience and training and to enable individuals employed under community work experience programs to move promptly into regular

public or private employment. The facilities of the State public employment offices may be utilized to find employment opportunities for recipients under this program. Community work experience programs shall be limited to projects which serve a useful public purpose in fields such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, and day care. To the extent possible, the prior training, experience, and skills of a recipient shall be utilized in making appropriate work experience assignments. A community work experience program established under this section shall provide—

“(A) appropriate standards for health, safety, and other conditions applicable to the performance of work;

“(B) that the program does not result in displacement of persons currently employed, or the filling of established unfilled position vacancies;

“(C) reasonable conditions of work, taking into account the geographic region, the residence of the participants, and the proficiency of the participants;

“(D) that participants will not be required, without their consent, to travel an unreasonable distance from their homes or remain away from their homes overnight;

“(E) that the maximum number of hours in any month that a participant may be required to work is that number which equals the amount of aid payable with respect to the family of which such individual is a member under the State plan approved under this part, divided by the greater of the Federal or the applicable State minimum wage; and

“(F) that provision will be made for transportation and other costs, not in excess of an amount established by the Secretary, reasonably necessary and directly related to participation in the program.

“(2) Nothing contained in this section shall be construed as authorizing the payment of aid under this part as compensation for work performed, nor shall a participant be entitled to a salary or to any other work or training expense provided under any other provision of law by reason of his participation in a program under this section.

“(3) Nothing in this part or part C, or in any State plan approved under this part, shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate, whether or not such terms, conditions, and cases are consistent with section 402(a)(19) or part (C)) a community work experience program in accordance with this section.

“(b)(1) Each recipient of aid under the plan who is registered under section 402(a)(19) shall participate, upon referral by the State agency, in a community work experience program unless such recipient is currently employed for no fewer than 80 hours a month and is earning an amount not less than the applicable minimum wage for such employment.

“(2) In addition to an individual described in paragraph (1), the State agency may also refer, for participation in programs under this section, an individual who would be required to register under section 402(a)(19)(A) but for the exception contained in clause (v) of such section (but only if the child for whom the parent or relative is caring is not under the age of three and child care is available for such child), or in clause (iii) of such section.

“(3) The chief executive officer of the State shall provide coordination between a community work experience program operated pursu-

42 USC 630.

Post, p. 854.

Aid recipients.

42 USC 630.

ant to this section and the work incentive program operated pursuant to part C so as to insure that job placement will have priority over participation in the community work experience program, and that individuals eligible to participate in both such programs are not denied aid under the State plan on the grounds of failure to participate in one such program if they are actively and satisfactorily participating in the other. The chief executive officer of the State may provide that part-time participation in both such programs may be required where appropriate.

Post, p. 854.

“(c) The provisions of section 402(a)(19)(F) shall apply to any individual referred to a community work experience program who fails to participate in such program in the same manner as they apply to an individual to whom section 402(a)(19) applies.

“(d) In the case of any State which makes expenditures in the form described in subsection (a) under its State plan approved under section 402, expenditures for the proper and efficient administration of the State plan, for purposes of section 403(a)(3), may not include the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in subsection (a) or the cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.”.

42 USC 603.

(b) Section 403(a)(3) of such Act is amended by inserting before the semicolon at the end thereof the following: “, or which is a service provided in connection with a community work experience program or work supplementation program under section 409 or 414”.

Ante, p. 846,
infra.

Repeal.

42 USC 609 note.

(c) Section 204(c)(2) of the Social Security Amendments of 1967 (Public Law 90-248) is repealed.

PROVIDING JOBS AS ALTERNATIVE TO AFDC

SEC. 2308. Part A of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

“WORK SUPPLEMENTATION PROGRAM

42 USC 614.

“SEC. 414. (a) It is the purpose of this section to allow a State to institute a work supplementation program under which such State, to the extent such State determines to be appropriate, may make jobs available, on a voluntary basis, as an alternative to aid otherwise provided under the State plan approved under this part.

42 USC 606.

“(b)(1) Notwithstanding the provisions of section 406 or any other provision of law, Federal funds may be paid to a State under this part, subject to the provisions of this section, with respect to expenditures incurred in operating a work supplementation program under this section.

42 USC 630.

“(2) Nothing in this part or part C, or in any State plan approved under this part, shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate, whether or not such terms, conditions, and cases are consistent with section 402(a)(19) or part C) a work supplementation program in accordance with this section.

42 USC 602.

“(3) Notwithstanding section 402(a)(23) or any other provision of law, a State may adjust the levels of the standards of need under the State plan as the State determines to be necessary and appropriate for carrying out a work supplementation program under this section.

“(4) Notwithstanding section 402(a)(1) or any other provision of law, a State operating a work supplementation program under this

section may provide that the needs standards in effect in those areas of the State in which such program is in operation may be different from the needs standards in effect in the areas in which such program is not in operation, and such State may provide that the needs standards for categories of recipients of aid may vary among such categories as the State determines to be appropriate on the basis of ability to participate in the work supplementation program.

“(5) Notwithstanding any other provision of law, a State may make further adjustments in the amounts of aid paid under the plan to different categories of recipients (as determined under paragraph (4)) in order to offset increases in benefits from needs related programs (other than the State plan approved under this part) as the State determines to be necessary and appropriate to further the purposes of the work supplementation program.

“(6) Notwithstanding section 402(a)(8) or any other provision of law, a State operating a work supplementation program under this section may reduce or eliminate the amount of earned income to be disregarded under the State plan as the State determines to be necessary and appropriate to further the purposes of the work supplementation program.

Ante, p. 843.

“(c)(1) A work supplementation program operated by a State under this section shall provide that any individual who is an eligible individual (as determined under paragraph (2)) may choose to take a supplemented job (as defined in paragraph (3)) to the extent supplemented jobs are available under the program. Payments by the State to individuals or to employers under the program shall be expenditures incurred by the State for aid to families with dependent children, except as limited by subsection (d).

Work
supplementation
program.

“(2) For purposes of this section, an eligible individual is an individual who is in a category which the State determines shall be eligible to participate in the work supplementation program, and who would, at the time of his placement in such job, be eligible for assistance under the State plan if such State did not have a work supplementation program in effect and had not altered its State plan accordingly, as such State plan was in effect in May 1981, or as modified thereafter as required by Federal law.

“(3) For purposes of this section, a supplemented job is—

“(A) a job position provided to an eligible individual by the State or local agency administering the State plan under this part;

“(B) a job position provided to an eligible individual by a public or nonprofit entity for which all or part of the wages are paid by such State or local agency; or

“(C) a job position provided to an eligible individual by a proprietary entity involving the provision of child day care services for which all or part of the wages are paid by such State or local agency, but only if such entity does not claim a credit for any part of the wages paid to such eligible individual under section 40 of the Internal Revenue Code of 1954 (relating to credit for expenses of the work incentive program) or section 44B of such Code (relating to credit for employment of certain new employees).

26 USC 40.

26 USC 44B.

A State may provide or subsidize any job position under the program as such State determines to be appropriate, but acceptance of any such position shall be voluntary.

“(d) The amount of the Federal payment to a State under section 403 for any quarter for expenditures incurred in operating a work

42 USC 603.

supplementation program shall not exceed an amount equal to the difference between—

42 USC 603.

“(1) the amount which would have been paid under section 403 to such State for such quarter under the State plan if it did not have a work supplementation program in effect and had not altered its State plan accordingly, as such State plan was in effect in May 1981, or as modified thereafter as required by Federal law; and

“(2) the amount paid to such State under section 403 for such quarter exclusive of the amount so paid for such quarter for the work supplementation program.

“(e)(1) Nothing in this section shall be construed as requiring a State or local agency administering the State plan to provide employee status to any eligible individual to whom it provides a job position under the work supplementation program, or with respect to whom it provides all or part of the wages paid to such individual by another entity under such program.

“(2) Nothing in this section shall be construed as requiring such State or local agency to provide that eligible individuals filling job positions provided by other entities under such program be provided employee status by such entity during the first 13 weeks during which they fill such position.

“(3) Wages paid under a work supplementation program shall be considered to be earned income for purposes of any provision of law.

“(f) Any work supplementation program operated by a State shall be administered by—

42 USC 602.

“(1) the agency designated to administer or supervise the administration of the State plan under section 402(a)(3); or

Ante, p. 846.

“(2) the agency (if any) designated to administer the community work experience program under section 409.

“(g) Any State which chooses to operate a work supplementation program under this section may choose to provide that any individual who participates in such program, and any child or relative of such individual (or other individual living in the same household as such individual) who would be eligible for aid under the State plan approved under this part if such State did not have a work supplementation program, shall be considered individuals receiving aid under the State plan approved under this part for purposes of eligibility for medical assistance under the State plan approved under title XIX.

42 USC 1396.

“(h) No individual receiving a grant under the State plan shall be excused, by reason of the fact that such State has a work supplementation program, from any requirement of this part or part C relating to work requirements.”.

42 USC 630.

WORK INCENTIVE DEMONSTRATION PROGRAM

SEC. 2309. Part C of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

“WORK INCENTIVE DEMONSTRATION PROGRAM

42 USC 645.

42 USC 601.

“SEC. 445. (a) Notwithstanding any other provision of this part and part A of this title, any State may elect as an alternative to the work incentive program otherwise provided in this part, and subject to the provisions of this section, to operate a work incentive demonstration program for the purpose of demonstrating single agency administra-

tion of the work-related objectives of this Act, and to receive payments under the provisions of this section.

“(b)(1) Not later than sixty days following the date of the enactment of this section, the Governor of a State which desires to operate a work incentive demonstration program under this section shall submit to the Secretary of Health and Human Services a letter of application stating such intent. Accompanying the letter of application shall be a State program plan which must—

State program plan.

“(A) provide that the agency conducting the demonstration program within the State shall be the single State agency which administers or supervises the administration of the State plan under part A of this title;

“(B) provide that all persons eligible for or receiving assistance under the aid to families with dependent children program shall be eligible to participate in, and shall be required to participate in, the work incentive demonstration program, subject to the same criteria for participation in such demonstration program as are in effect under this part and part A during the month before the month in which the demonstration program commences;

42 USC 601.

“(C) provide that the criteria for participation in the work incentive demonstration program shall be uniform throughout the State;

“(D) provide a statement of the objectives which the State expects to meet through operation of a work incentive demonstration program, with emphasis on how the State expects to maximize client placement in nonsubsidized private sector employment;

“(E) describe the techniques to be used to achieve the objectives of the work incentive demonstration program, which may include but shall not be limited to: maximum periods of participation, job training, job find clubs, grant diversion to either public or private sector employers, services contracts with State employment services, prime sponsors under the Comprehensive Employment and Training Act of 1973, or private placement agencies, targeted jobs tax credit outreach campaigns, and performance-based placement incentives; and

29 USC 801 note.

“(F) set forth the format and frequency of reporting of information regarding operation of the work incentive demonstration program.

“(2) A State's application to participate in the work incentive demonstration program shall be deemed approved unless the Secretary of Health and Human Services notifies the State in writing of disapproval within forty-five days of the date of application. The Secretary of Health and Human Services shall set forth the reasons for disapproval and provide an opportunity for resubmission of the plan within forty-five days of the receipt of the notice of disapproval. An application shall not be finally disapproved unless the Secretary of Health and Human Services determines that the State's program plan would be less effective than the requirements set forth in this title, other than this section.

Disapproval notification.

“(3) The Secretary of Health and Human Services shall furnish copies of approved plans, statistical reports, and evaluation reports to the Secretary of Labor.

Copies to Labor Secretary.

“(c) Subject to the statement of objectives and description of techniques to be used in implementing its work incentive demonstration program, as set forth in its program plan, a State shall be free to design a program which best addresses its individual needs, makes best use of its available resources, and recognizes its labor market

conditions. Other than criteria for participation in the State's work incentive demonstration project, which shall be uniform throughout the State, the components of the program may vary by geographic area or by political subdivision.

Program
duration.

"(d) A State's work incentive demonstration program, if initially approved, shall be in force for a three-year period. During this period, the State may elect to use up to six months for planning purposes. During such planning period, all requirements of part A and this part C shall remain in full force and effect.

42 USC 601, 630.

Evaluations by
HHS Secretary.

"(e) The Secretary of Health and Human Services shall conduct two evaluations of a State's work incentive demonstration program. The first evaluation shall be conducted at the conclusion of the first twelve months of operation of the demonstration program. The second evaluation shall be conducted at the conclusion of the demonstration program. Both evaluations shall compare placement rates during the demonstration program with placement rates achieved during a number of previous years, to be determined by the Secretary of Health and Human Services.

Funding.

"(f)(1) For each year of its demonstration program, a State which is operating such program shall be funded in an amount equal to its initial annual 1981 allocation under the work incentive program set forth in this part, plus any other Federal funds which the State may properly receive under any statute for establishing work programs for recipients of aid to families with dependent children.

"(2) Such funds shall only be used by the State for administering and operating its work incentive demonstration program. These funds shall not be used for direct grants of assistance under the aid to families with dependent children program.

"(g) Earnings derived from participation in a State's work incentive demonstration program shall not result in a determination of financial ineligibility for assistance under the aid to families with dependent children program."

EFFECT OF PARTICIPATION IN A STRIKE ON ELIGIBILITY FOR AFDC

42 USC 602.

SEC. 2310. Section 402(a) of the Social Security Act is amended by inserting after paragraph (20) the following new paragraph:

"(21) provide—

"(A) that, for purposes of this part, participation in a strike shall not constitute good cause to leave, or to refuse to seek or accept employment; and

"(B)(i) that aid to families with dependent children is not payable to a family for any month in which any caretaker relative with whom the child is living is, on the last day of such month, participating in a strike, and (ii) that no individual's needs shall be included in determining the amount of aid payable for any month to a family under the plan if, on the last day of such month, such individual is participating in a strike;"

AGE LIMIT OF DEPENDENT CHILD

42 USC 606.

SEC. 2311. Section 406(a)(2) of the Social Security Act is amended to read as follows: "(2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of nineteen and a full-time student in a secondary school (or in the equivalent level of vocational or technical training), if, before he attains age nineteen, he may reason-

ably be expected to complete the program of such secondary school (or such training);”.

LIMITATION ON AFDC TO PREGNANT WOMEN

SEC. 2312. (a) Section 406(b) of the Social Security Act is amended by striking out “dependent children” the second place it appears in the matter that precedes clause (1) and inserting in lieu thereof “dependent children, or, at the option of the State, a pregnant woman but only if it has been medically verified that the child is expected to be born in the month such payments are made or within the three-month period following such month of payment, and who, if such child had been born and was living with her in the month of payment, would be eligible for aid to families with dependent children”.

42 USC 606.

(b) Section 406 of such Act is amended by adding at the end thereof the following new subsection:

“(g)(1) Notwithstanding the provisions of subsection (b), the term ‘aid to families with dependent children’ does not mean any—
 “(A) amount paid to meet the needs of an unborn child; or
 “(B) amount paid (or by which a payment is increased) to meet the needs of a woman occasioned by or resulting from her pregnancy, unless, as has been medically verified, the woman’s child is expected to be born in the month such payments are made (or increased) or within the three-month period following such month of payment.”

“Aid to families with dependent children.”

“(2) Notwithstanding paragraph (1), a State may provide that for purposes of title XIX a pregnant woman shall be deemed to be a recipient of aid to families with dependent children under this part if she would be eligible for such aid if such child had been born and was living with her in the month of payment, and such pregnancy has been medically verified.”.

42 USC 1396.

AID TO FAMILIES WITH DEPENDENT CHILDREN BY REASON OF UNEMPLOYMENT OF A PARENT

SEC. 2313. (a) Section 407 of the Social Security Act is amended as follows:

42 USC 607.

(1) the heading is amended to read “DEPENDENT CHILDREN OF UNEMPLOYED PARENTS”;

(2) subsection (a) is amended by striking out “his father” and inserting in lieu thereof “the parent who is the principal earner”;

(3) subsection (b)(1) is amended—

(A) by striking out “such child’s father” in subparagraph (A) and inserting in lieu thereof “whichever of such child’s parents is the principal earner”; and

(B) by striking out “father” in subparagraph (B) and inserting in lieu thereof “parent”;

(4) subsection (b)(2) is amended—

(A) by striking out “fathers” in subparagraph (A) and inserting in lieu thereof “unemployed parents”, and

(B) by striking out “father” in subparagraph (C) (i) and (ii) and in subparagraph (D) and inserting in lieu thereof “parent described in paragraph (1)(A)”;

(5) subsection (c) is amended by striking out “father” both times it appears and inserting in lieu thereof “parent”;

(6) subsection (d) is amended—

(A) by striking out “and” at the end of paragraph (2);

(B) by striking out the period at the end of paragraph (3) and inserting in lieu thereof “; and”; and

(C) by adding at the end thereof the following new paragraph:

Definition.

“(4) the phrase ‘whichever of such child’s parents is the principal earner’, in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.”; and

(7) subsection (e) is amended by striking out “fathers” and inserting in lieu thereof “parents”.

94 Stat. 461.

42 USC 602.

(b) Section 402(a)(19)(A) of such Act is amended—

(1) by striking out “mother” in clause (v) and inserting in lieu thereof “parent”; and

(2) by striking out “mother or other female caretaker of a child, if the father or another adult male relative” in clause (vi) and inserting in lieu thereof “parent or other caretaker of a child who is deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, if another adult relative”; and

(3)(A) by striking out “or” at the end of clause (vi); and

(B) by striking out the semicolon at the end of clause (vii) and inserting in lieu thereof “; or”; and

(C) by adding at the end thereof the following new clause:

“(viii) the parent of a child who is deprived of parental support or care by reason of the unemployment of a parent, if the other parent (who is the principal earner, as defined in section 407(d)) is not excluded by the preceding clauses of this subparagraph.”; and

42 USC 607.

(4) in the matter following the numbered clauses—

(A) by striking out “her option” and inserting in lieu thereof “his or her option”; and

(B) by striking out “if she so desires” and inserting in lieu thereof “if he or she so desires”; and

(C) by striking out “to her” and inserting in lieu thereof “to him or her”; and

(D) by striking out “she should decide” and inserting in lieu thereof “he or she should decide”.

94 Stat. 461.

42 USC 602.

(c)(1) Section 402(a)(19)(F) of such Act is amended by redesignating clauses (ii) through (iv) as clauses (iii) through (v), respectively, and by inserting after clause (i) the following new clause:

“(ii) if the parent who has been designated as the principal earner, for purposes of section 407, makes such refusal, aid will be denied to all members of the family.”;

42 USC 607.

(2) Section 407(b)(2)(C)(i) of such Act is amended by striking out “not registered” and inserting in lieu thereof “not currently registered”.

WORK REQUIREMENTS FOR AFDC RECIPIENTS

42 USC 602.

SEC. 2314. (a) Section 402(a)(19)(A)(i) of the Social Security Act is amended to read as follows:

“(i) a child who is under age 16 or attending, full-time, an elementary, secondary, or vocational (or technical) school.”;

(b) Section 402(a)(19)(A)(v) of such Act (as amended by section 2313(b)(1) of this Act) is amended to read as follows:

“(v) the parent or other relative of a child under the age of six who is personally providing care for the child with only very brief and infrequent absences from the child;”.

RETROSPECTIVE BUDGETING AND MONTHLY REPORTING

SEC. 2315. (a) Section 402(a) of the Social Security Act is amended by inserting after paragraph (12) the following new paragraphs: 42 USC 602.

“(13) provide that—

“(A) except as provided in subparagraph (B), the State agency (i) will determine a family’s eligibility for aid for a month on the basis of the family’s income, composition, resources, and other similar relevant circumstances during such month, and (ii) will determine the amount of such aid on the basis of the income and other relevant circumstances in the first or, at the option of the State but only where the Secretary determines it to be appropriate, second month preceding such month; and

“(B) in the case of the first month, or at the option of the State but only where the Secretary determines it to be appropriate, the first and second months, in a period of consecutive months for which aid is payable, the State agency will determine the amount of aid on the basis of the family’s income and other relevant circumstances in such first or second month;

“(14)(A) provide that the State agency will require each family to which it furnishes aid to families with dependent children (or to which it would provide such aid but for paragraph (22) or (32)) to report, as a condition to the continued receipt of such aid (or to continuing to be deemed to be a recipient of such aid), each month to the State agency on—

“(i) the income received, family composition, and other relevant circumstances during the prior month; and

“(ii) the income and resources it expects to receive, or any changes in circumstances affecting continued eligibility or benefit amount, that it expects to occur, in that month (or in future months);

except that with the prior approval of the Secretary the State may select categories of recipients who may report at specified less frequent intervals upon the State’s showing to the satisfaction of the Secretary that to require individuals in such categories to report monthly would result in unwarranted expenditures for administration of this paragraph; and

“(B) that, in addition to whatever action may be appropriate based on other reports or information received by the State agency, the State agency will take prompt action to adjust the amount of assistance payable, as may be appropriate, on the basis of the information contained in the report (or upon the failure of the family to furnish a timely report), and will give an appropriate explanatory notice, concurrent with its action, to the family;”.

(b) Section 403(a) of such Act is amended by adding at the end thereof the following sentence: “No payment shall be made under this subsection with respect to amounts paid to supplement or otherwise increase the amount of aid to families with dependent children found payable in accordance with section 402(a)(13) if such amount is determined to have been paid by the State in recognition of 42 USC 603.

Supra.

the current or anticipated needs of a family (other than with respect to the first or first and second months of eligibility).”.

PROHIBITION AGAINST PAYMENT OF AID IN AMOUNTS BELOW TEN
DOLLARS

SEC. 2316. Section 402(a) of the Social Security Act (as amended by section 2306 of this Act) is amended—

- (1) by striking out “and” at the end of paragraph (30);
- (2) by striking out the period at the end of paragraph (31) and inserting in lieu thereof “; and”; and
- (3) by adding after paragraph (31) the following new paragraph:
“(32) provide that no payment of aid shall be made under the plan for any month if the amount of such payment, as determined in accordance with the applicable provisions of the plan and of this part, would be less than \$10, but an individual with respect to whom a payment of aid under the plan is denied solely by reason of this paragraph is deemed to be a recipient of aid but shall not be eligible to participate in a community work experience program.”

REMOVAL OF LIMIT ON RESTRICTED PAYMENTS IN A STATE'S AFDC
PROGRAM

42 USC 603.

SEC. 2317. (a) Section 403(a) of the Social Security Act is amended by striking out the first unnumbered paragraph following paragraph (5).

42 USC 606.

(b) Section 406(b) of such Act is amended by adding at the end thereof the following new sentence: “Payments of the type described in clause (2) shall not be subject to the requirements of clauses (A) through (E) of such clause (2), when they are made in the manner described in clause (2) at the request of the family member to whom payment would otherwise be made in an unrestricted manner.”.

ADJUSTMENT FOR INCORRECT PAYMENTS

42 USC 602.

Ante, p. 852.

SEC. 2318. Section 402(a) of the Social Security Act is amended by inserting after paragraph (21) the following new paragraph:

“(22) provide that the State agency will promptly take all necessary steps to correct any overpayment or underpayment of aid under the State plan, and, in the case of—

“(A) an overpayment to an individual who is a current recipient of such aid, recovery will be made by repayment by the individual or by reducing the amount of any future aid payable to the family of which he is a member, except that such recovery shall not result in the reduction of aid payable for any month, such that the aid, when added to such family's liquid resources and to its income (without application of paragraph (8)), is less than 90 percent of the amount payable under the State plan to a family of the same composition with no other income (and, in the case of an individual to whom no payment is made for a month solely by reason of recovery of an overpayment, such individual shall be deemed to be a recipient of aid for such month);

“(B) an overpayment to any individual who is no longer receiving aid under the plan, recovery shall be made by

appropriate action under State law against the income or resources of the individual or the family; and

“(C) an underpayment, the corrective payment shall be disregarded in determining the income of the family, and shall be disregarded in determining its resources in the month the corrective payment is made and in the following month;”.

REDUCED FEDERAL MATCHING OF STATE AND LOCAL AFDC TRAINING COSTS

SEC. 2319. (a) Section 403(a)(3)(A) of the Social Security Act, as in effect in the fifty States and the District of Columbia, is repealed. 42 USC 603.

(b) Section 403(a)(3)(A)(iii) of such Act, as in effect in Puerto Rico, Guam, and the Virgin Islands, is repealed. 42 USC 603 note.

(c) The first sentence of section 403(d)(1) of such Act is amended by striking out all that precedes “with respect to” and inserting in lieu thereof “Notwithstanding any provision of subsection (a)(3), the applicable rate under such subsection shall be 90 per centum”. 94 Stat. 462.

(d) The repeals made by this section shall apply to expenditures made after September 30, 1981. 42 USC 603 note.

ELIGIBILITY OF ALIENS FOR AFDC

SEC. 2320. (a) Section 402(a) of the Social Security Act (as amended by section 2316 of this Act) is further amended—

(1) by striking out “and” at the end of paragraph (31) ;

(2) by striking out the period at the end of paragraph (32) and inserting in lieu thereof “; and”; and

(3) by adding immediately after paragraph (32) the following new paragraph:

“(33) provide that in order for any individual to be considered a dependent child, a caretaker relative whose needs are to be taken into account in making the determination under paragraph (7), or any other person whose needs should be taken into account in making such a determination with respect to the child or relative, such individual must be either (A) a citizen, or (B) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 207(c) of the Immigration and Nationality Act (or of section 203(a)(7) of such Act prior to April 1, 1980), or as a result of the application of the provisions of section 208 or 212(d)(5) of such Act).”.

(b)(1) Section 402(a)(7) of such Act (as amended by section 2302 of this Act) is further amended by inserting “and section 415” after “paragraph (31)”. 94 Stat. 103.
8 USC 1157.
8 USC 1153.
94 Stat. 105, 107.
8 USC 1158,
1182.

(2) Part A of title IV of such Act (as amended by section 2308 of this Act) is further amended by adding at the end thereof the following new section:

“ATTRIBUTION OF SPONSOR’S INCOME AND RESOURCES TO ALIEN

“SEC. 415. (a) For purposes of determining eligibility for and the amount of benefits under a State plan approved under this part for an individual who is an alien described in clause (B) of section 402(a)(33), the income and resources of any person who (as a sponsor of such individual’s entry into the United States) executed an affidavit of 42 USC 615.
Supra.

support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the unearned income and resources of such individual (in accordance with subsections (b) and (c)) for a period of three years after the individual's entry into the United States, except that this section is not applicable if such individual is a dependent child and such sponsor (or such sponsor's spouse) is the parent of such child.

"(b)(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any month shall be determined as follows:

"(A) the total amount of earned and unearned income of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such month;

"(B) the amount determined under subparagraph (A) shall be reduced by an amount equal to the sum of—

"(i) the lesser of (I) 20 percent of the total of any amounts received by the sponsor and his spouse in such month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by them in producing self-employment income in such month, or (II) \$175;

"(ii) the cash needs standard established by the State under its plan for a family of the same size and composition as the sponsor and those other individuals living in the same household as the sponsor who are claimed by him as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making a determination under section 402(a)(7);

"(iii) any amounts paid by the sponsor (or his spouse) to individuals not living in such household who are claimed by him as dependents for purposes of determining his Federal personal income tax liability; and

"(iv) any payments of alimony or child support with respect to individuals not living in such household.

"(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any month shall be determined as follows:

"(A) the total amount of the resources (determined as if the sponsor were applying for aid under the State plan approved under this part) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined; and

"(B) the amount determined under subparagraph (A) shall be reduced by \$1,500.

"(c)(1) Any individual who is an alien shall, during the period of three years after entry into the United States, in order to be eligible for aid under a State plan approved under this part, be required to provide to the State agency administering such plan such information and documentation with respect to his sponsor as may be necessary in order for the State agency to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the State agency such information and documentation as it may request and which such alien or his sponsor provided in support of such alien's immigration application.

"(2) The Secretary shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to them and required in order to make any determination under this section will be provided by them to the Secretary (who may, in

Ante, p. 844.

Sponsor
information and
documentation.

turn, make such information available, upon request, to a concerned State agency), and whereby the Secretary of State and Attorney General will inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

“(d) Any sponsor of an alien, and such alien, shall be jointly and severally liable for an amount equal to any overpayment of aid under the State plan made to such alien during the period of three years after such alien’s entry into the United States, on account of such sponsor’s failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause of such failure existed. Any such overpayment which is not repaid to the State or recovered in accordance with the procedures generally applicable under the State plan to the recoupment of overpayments shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this Act.

Overpayment liability.

“(e)(1) In any case where a person is the sponsor of two or more alien individuals who are living in the same home, the income and resources of such sponsor (and his spouse), to the extent they would be deemed the income and resources of any one of such individuals under the preceding provisions of this section, shall be divided into two or more equal shares (the number of shares being the same as the number of such alien individuals) and the income and resources of each such individual shall be deemed to include one such share.

“(2) Income and resources of a sponsor (and his spouse) which are deemed under this section to be the income and resources of any alien individual in a family shall not be considered in determining the need of other family members except to the extent such income or resources are actually available to such other members.

“(f) The provisions of this section shall not apply with respect to any alien who is—

“(1) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act;

8 USC 1153.

“(2) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c) of such Act;

94 Stat. 103.
8 USC 1157.

“(3) paroled into the United States as a refugee under section 212(d)(5) of such Act;

94 Stat. 107.
8 USC 1182.

“(4) granted political asylum by the Attorney General under section 208 of such Act; or

94 Stat. 105.
8 USC 1158.

“(5) a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422).”

94 Stat. 1809.
8 USC 1522 note.
Effective dates.
42 USC 615 note.

(c) The amendments made by subsection (a) shall be effective on the date of the enactment of this Act. The amendments made by subsection (b) shall be effective with respect to individuals applying for aid to families with dependent children under any approved State plan for the first time after September 30, 1981.

EFFECTIVE DATE

SEC. 2321. (a) Except as otherwise specifically provided in the preceding sections of this chapter or in subsection (b), the provisions of this chapter and the amendments and repeals made by this chapter shall become effective on October 1, 1981.

42 USC 602 note.

42 USC 601.

"Session of a
State's
legislature."

(b) If a State agency administering a plan approved under part A of title IV of the Social Security Act demonstrates, to the satisfaction of the Secretary of Health and Human Services, that it cannot, by reason of State law, comply with the requirements of an amendment made by this chapter to which the effective date specified in subsection (a) applies, the Secretary may prescribe that, in the case of such State, the amendment will become effective beginning with the first month beginning after the close of the first session of such State's legislature ending on or after October 1, 1981. For purposes of the preceding sentence, the term "session of a State's legislature" includes any regular, special, budget, or other session of a State legislature.

CHAPTER 2—CHILD SUPPORT ENFORCEMENT

COLLECTION OF PAST-DUE CHILD AND SPOUSAL SUPPORT FROM FEDERAL TAX REFUNDS

SEC. 2331. (a) Part D of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

"COLLECTION OF PAST-DUE SUPPORT FROM FEDERAL TAX REFUNDS

42 USC 664.

"SEC. 464. (a) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which has been assigned to such State pursuant to section 402(a)(26), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to the past-due support, and pay such amount to the State agency (together with notice of the individual's home address) for distribution in accordance with section 457(b)(3).

42 USC 602.

42 USC 657.
Regulations.

"(b) The Secretary of the Treasury shall issue regulations, approved by the Secretary of Health and Human Services, prescribing the time or times at which States must submit notices of past-due support, the manner in which such notices must be submitted, and the necessary information that must be contained in or accompany the notices. The regulations shall specify the minimum amount of past-due support to which the offset procedure established by subsection (a) may be applied, and the fee that a State must pay to reimburse the Secretary of the Treasury for the full cost of applying the offset procedure, and provide that the Secretary of the Treasury will advise the Secretary of Health and Human Services, not less frequently than annually, of the States which have furnished notices of past-due support under subsection (a), the number of cases in each State with respect to which such notices have been furnished, the amount of support sought to be collected under this subsection by each State, and the amount of such collections actually made in the case of each State.

"Past-due
support."

"(c) As used in this part the term 'past-due support' means the amount of a delinquency, determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a child, or of a child and the parent with whom the child is living."

42 USC 654.

(b) Section 454 of such Act is amended—

- (1) by striking out “and” at the end of paragraph (16);
- (2) by striking out the period at the end of paragraph (17) and inserting in lieu thereof “; and”; and
- (3) by adding at the end thereof the following new paragraph:
 “(18) provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 464, and take all steps necessary to implement and utilize such procedures.”.

Ante, p. 860.

(c) Section 6402 of the Internal Revenue Code of 1954 is amended— 26 USC 6402.

- (1) by striking out in subsection (a) thereof “shall refund” and inserting in lieu thereof “shall, subject to subsection (c), refund”; and

- (2) by adding at the end thereof the following new subsection:

“(c) OFFSET OF PAST-DUE SUPPORT AGAINST OVERPAYMENTS.—The amount of any overpayment to be refunded to the person making the overpayment shall be reduced by the amount of any past-due support (as defined in section 464(c) of the Social Security Act) owed by that person of which the Secretary has been notified by a State in accordance with section 464 of the Social Security Act. The Secretary shall remit the amount by which the overpayment is so reduced to the State to which such support has been assigned and notify the person making the overpayment that so much of the overpayment as was necessary to satisfy his obligation for past-due support has been paid to the State. This subsection shall be applied to an overpayment prior to its being credited to a person’s future liability for an internal revenue tax.”.

COLLECTION OF SUPPORT FOR CERTAIN ADULTS

SEC. 2332. (a) Section 451 of the Social Security Act is amended by striking out “children” and inserting in lieu thereof “children and the spouse (or former spouse) with whom such children are living” and by striking out “child support” and inserting in lieu thereof “child and spousal support”. 42 USC 651.

- (b)(1) Section 452(a) of such Act is amended—

42 USC 652.

- (A) in paragraph (1), by inserting “and support for the spouse (or former spouse) with whom the absent parent’s child is living” after “child support”;

- (B) in paragraph (7), by inserting “and spousal” after “child”; and

- (C) in paragraph (10)(C), by inserting “(with separate identification of the number in which collection of spousal support was involved)” after “child support cases”.

- (2) Section 452(b) of such Act is amended—

- (A) by inserting “, including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A,” after “assigned to the State” in the first sentence;

42 USC 601.

- (B) by striking out “court order” in the second sentence and inserting in lieu thereof “court or administrative order”; and

- (C) by striking out “United States” in the second sentence and inserting in lieu thereof “Secretary of the Treasury”; and

- (D) by inserting immediately after the second sentence the following new sentence: “All reimbursements shall be credited to the appropriation accounts which bore all or part of the costs involved in making the collections.”.

42 USC 653.

(c) Section 453(c)(1) of such Act is amended by striking out "child support" and inserting in lieu thereof "child and spousal support".

42 USC 654.

(d) Section 454 of such Act is amended—

(1) by striking out "CHILD SUPPORT" in the heading and inserting in lieu thereof "CHILD AND SPOUSAL SUPPORT";

(2) by striking out "child support" in the matter preceding paragraph (1) and inserting in lieu thereof "child and spousal support";

(3) in paragraph (4)(B), by striking out the comma immediately following the first parenthetical phrase and inserting in lieu thereof "and, at the option of the State, from such parent for his spouse (or former spouse) receiving aid to families with dependent children (but only if a support obligation has been established with respect to such spouse),";

(4) in paragraph (5), by striking out "child support payments" and inserting in lieu thereof "support payments" and by striking out "collected for a child" and inserting in lieu thereof "collected for an individual";

(5) in paragraph (9)(C), by striking out "of a child or children" and inserting in lieu thereof "of the child or children or the parent of such child or children";

(6) in paragraph (11), by striking out "child"; and

(7) in paragraph (16), by striking out "child" each place it appears.

42 USC 657.

(e) Section 457 of such Act is amended—

(1) by striking out "child" in the portion of subsection (b) that precedes paragraph (1); and

(2) by striking out "child" each place it appears in subsection (c).

42 USC 660.

(f) The heading of section 460 of such Act is amended by striking out "CHILD".

26 USC 6305.

(g) Section 6305(a)(4) of the Internal Revenue Code of 1954, (relating to collection of certain liability) is amended by striking out "court order" and inserting in lieu thereof "court or administrative order".

COST OF COLLECTION AND OTHER SERVICES FOR NON-AFDC FAMILIES

42 USC 654.

SEC. 2333. (a) Section 454(6) of the Social Security Act is amended—

(1) by striking out "such services" in clause (B) and inserting in lieu thereof "services under the State plan (other than collection of support)"; and

(2) by amending clause (C) to read as follows: "(C) the State will retain, but only if it is the State which makes the collection, the fee imposed under State law as required under paragraph (19);".

(b) Section 454 of such Act (as amended by section 2331(b) of this Act) is further amended—

(1) by striking out "and" at the end of paragraph (17);

(2) by striking out the period at the end of paragraph (18) and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new paragraph:
 "(19) provide that a fee shall be imposed on the individual who owes a child or spousal support obligation, in accordance with State law, with respect to all such child and spousal support obligations for which collection is made by the State agency under this part on behalf of an individual not otherwise eligible for collection services (as determined for purposes of paragraph (6)) in an amount equal to 10 percent of the amount so owed (and for purposes of this part, no part of the amount collected shall be

considered to be a fee collected except amounts which exceed the actual amount of support owed).”.

(c) Section 453(a) of such Act is amended by adding at the end thereof the following new sentence: “In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.”.

42 USC 653.

CHILD SUPPORT OBLIGATIONS NOT DISCHARGED BY BANKRUPTCY

SEC. 2334. (a) Section 456 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 656.

“(b) A debt which is a child support obligation assigned to a State under section 402(a)(26) is not released by a discharge in bankruptcy under title 11, United States Code.”.

42 USC 602.

(b) Section 523(a)(5)(A) of title 11, United States Code, is amended by inserting before the semicolon the following: “(other than debts assigned pursuant to section 402(a)(26) of the Social Security Act)”.

(c) The amendments made by this section shall become effective on the date of the enactment of this Act.

Effective date.
42 USC 656 note.

CHILD SUPPORT INTERCEPT OF UNEMPLOYMENT BENEFITS

SEC. 2335. (a) Section 454 of the Social Security Act (as amended by section 2333(b) of this Act) is amended by striking out “and” at the end of paragraph (18), by striking out the period at the end of paragraph (19) and inserting in lieu thereof “; and”, and by adding at the end thereof the following new paragraph:

“(20) provide that the agency administering the plan—

“(A) shall determine on a periodic basis, from information supplied pursuant to section 508 of the Unemployment Compensation Amendments of 1976, whether any individuals receiving compensation under the State’s unemployment compensation law (including amounts payable pursuant to any agreement under any Federal unemployment compensation law) owe child support obligations which are being enforced by such agency, and

29 USC 49b.
42 USC 603a.

“(B) shall enforce any such child support obligations which are owed by such an individual but are not being met—

“(i) through an agreement with such individual to have specified amounts withheld from compensation otherwise payable to such individual and by submitting a copy of any such agreement to the State agency administering the unemployment compensation law, or

“(ii) in the absence of such an agreement, by bringing legal process (as defined in section 462(e) of this Act) to require the withholding of amounts from such compensation.”.

42 USC 662.

(b)(1) Subsection (e) of section 303 of the Social Security Act is amended by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and by inserting after paragraph (1) the following new paragraph:

42 USC 503.

“(2)(A) The State agency charged with the administration of the State law—

“(i) shall require each new applicant for unemployment compensation to disclose whether or not such applicant owes child

support obligations (as defined in the last sentence of this subsection),

“(ii) shall notify the State or local child support enforcement agency enforcing such obligations, if any applicant discloses under clause (i) that he owes child support obligations and he is determined to be eligible for unemployment compensation, that such applicant has been so determined to be eligible,

“(iii) shall deduct and withhold from any unemployment compensation otherwise payable to an individual—

“(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

“(II) the amount (if any) determined pursuant to an agreement submitted to the State agency under section 454(20)(B)(i) of this Act, or

“(III) any amount otherwise required to be so deducted and withheld from such unemployment compensation through legal process (as defined in section 462(e)), and

“(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State or local child support enforcement agency.

Any amount deducted and withheld under clause (iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by such individual to the State or local child support enforcement agency in satisfaction of his child support obligations.

“(B) For purposes of this paragraph, the term ‘unemployment compensation’ means any compensation payable under the State law (including amounts payable pursuant to agreements under any Federal unemployment compensation law).

“(C) Each State or local child support enforcement agency shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by such State agency under this paragraph which are attributable to child support obligations being enforced by the State or local child support enforcement agency.”

(2) Paragraph (3) of section 303(e) of such Act (as redesignated by paragraph (1)) is amended by striking out “paragraph (1)” and inserting in lieu thereof “paragraph (1) or (2)”.

(3) The last sentence of paragraph (1) of such section 303(e) is amended by striking out “the preceding sentence” and inserting in lieu thereof “this subsection”.

(c) The amendments made by this section shall take effect on the date of the enactment of this Act, except that such amendments shall not be requirements under section 454 or 303 of the Social Security Act before October 1, 1982.

EFFECTIVE DATE

SEC. 2336. (a) Except as otherwise specifically provided in the preceding sections of this chapter or in subsection (b), the provisions of this chapter and the amendments and repeals made by this chapter shall become effective on October 1, 1981.

(b) If a State agency administering a plan approved under part D of title IV of the Social Security Act demonstrates, to the satisfaction of the Secretary of Health and Human Services, that it cannot, by reason of State law, comply with the requirements of an amendment made by this chapter to which the effective date specified in subsection (a) applies, the Secretary may prescribe that, in the case of such

Ante, p. 863.

42 USC 662.

“Unemployment compensation.”

Ante, p. 863.

Effective date.
42 USC 503 note.

42 USC 651 note.

42 USC 651.

State, the amendment will become effective beginning with the first month beginning after the close of the first session of such State's legislature ending on or after October 1, 1981. For purposes of the preceding sentence, the term "session of a State's legislature" includes any regular, special, budget, or other session of a State legislature.

Subtitle B—Supplemental Security Income Benefits

RETROSPECTIVE ACCOUNTING

SEC. 2341. (a) Section 1611(c) of the Social Security Act is amended 42 USC 1382. to read as follows:

"(c)(1) An individual's eligibility for a benefit under this title for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraph (2), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

"(2) The amount of such benefit for the month in which application for such benefits is filed or, if the Secretary so determines, for such month and the following month, and for any month following a month of ineligibility for such benefits (or, if the Secretary so determines, such month and the following month) shall be determined on the basis of the individual's (and eligible spouse's, if any) income and other relevant circumstances in such month.

"(3) For purposes of this subsection, an application shall be effective as of the first day of the month in which it is filed.

"(4) The Secretary may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Secretary shall apply, to the month preceding the month of removal, or, if the Secretary so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility."

Limitations
waiver.

(b) Section 1612(b)(3) of such Act is amended—

42 USC 1382a.

(1) by striking out "calendar quarter" each place it appears and inserting in lieu thereof "month";

(2) by striking out "such quarter" each place it appears and inserting in lieu thereof "such month";

(3) by striking out "\$60" and inserting in lieu thereof "\$20"; and

(4) by striking out "\$30" and inserting in lieu thereof "\$10".

(c)(1) The amendments made by this section shall be effective with respect to months after the first calendar quarter which ends more than five months after the month in which this Act is enacted.

Effective date.
42 USC 1382
note.

(2) The Secretary of Health and Human Services may, under conditions determined by him to be necessary and appropriate, make a transitional payment or payments during the first two months for which the amendments made by this section are effective. A transi-

Transitional
payments.

tional payment made under this section shall be deemed to be a payment of supplemental security income benefits.

ELIGIBILITY OF SSI RECIPIENTS FOR FOOD STAMPS

SEC. 2342. (a) Section 8(d) of Public Law 93-233 is amended to read as follows:

“(d) Upon the request of a State, the Secretary shall find, for purposes of the provisions specified in subsection (c), that the level of such State’s supplementary payments of the type described in section 1616(a) of the Social Security Act has been specifically increased for any month so as to include the bonus value of food stamps (and that such State meets the applicable requirements of subsection (c)(1)) if—

“(1) the Secretary has found (under this subsection or subsection (c), as in effect in December 1980) that such State’s supplementary payments in December 1980 were increased to include the bonus value of food stamps; and

“(2) such State continues without interruption to meet the requirements of section 1618 of such Act for each month after the month referred to in paragraph (1) and up to and including the month for which the Secretary is making the determination.”.

(b) The amendment made by subsection (a) shall become effective July 1, 1981.

PAYMENT TO STATES WITH RESPECT TO CERTAIN UNNEGOTIATED CHECKS

SEC. 2343. (a) Section 1631 of the Social Security Act is amended by adding at the end thereof the following new subsection:

“Payment to States With Respect to Certain Unnegotiated Checks

“(i)(1) The Secretary of the Treasury shall, on a monthly basis, notify the Secretary of all benefit checks issued under this title which include amounts representing State supplementary payments as described in paragraph (2) and which have not been presented for payment within one hundred and eighty days after the day on which they were issued.

“(2) The Secretary shall from time to time determine the amount representing the total of the State supplementary payments made pursuant to agreements under section 1616(a) of this Act and under section 212(b) of Public Law 93-66 which is included in all checks payable to individuals entitled to benefits under this title but not presented for payment within one hundred and eighty days after the day on which they were issued, and shall pay each State (or credit each State with) an amount equal to that State’s share of all such amount. Amounts not paid to the States shall be returned to the appropriation from which they were originally paid.

“(3) The Secretary, upon notice from the Secretary of the Treasury under paragraph (1), shall notify any State having an agreement described in paragraph (2) of all such benefit checks issued under that State’s agreement which were not presented for payment within one hundred and eighty days after the day on which they were issued.

“(4) The Secretary shall, to the maximum extent feasible, investigate the whereabouts and eligibility of the individuals whose benefit checks were not presented for payment within one hundred and eighty days after the day on which they were issued.”.

(b) The amendment made by subsection (a) shall become effective October 1, 1982.

FUNDING OF REHABILITATION SERVICES FOR SSI RECIPIENTS

SEC. 2344. Effective October 1, 1981, section 1615(d) of the Social Security Act is amended— 42 USC 1382d.

(1) by striking out “is authorized to pay to” and inserting in lieu thereof “is authorized to reimburse”;

(2) by inserting “for” before “the costs incurred”; and

(3) by striking out “individuals referred for such services pursuant to subsection (a)” and inserting in lieu thereof “individuals who are referred for such services pursuant to subsection (a) if such services result in their performance of substantial gainful activity which lasts for a continuous period of nine months. The determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 222(d)(1)”. 42 USC 422.

Subtitle C—Block Grants for Social Services

Social Services
Block Grant Act.

SHORT TITLE

SEC. 2351. This subtitle may be cited as the “Social Services Block Grant Act”. 42 USC 1305 note.

TITLE XX BLOCK GRANTS

SEC. 2352. (a) Title XX of the Social Security Act is amended to read as follows:

“TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

“PURPOSES OF TITLE; AUTHORIZATION OF APPROPRIATIONS

“SEC. 2001. For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of— 42 USC 1397.

“(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

“(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

“(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

“(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

“(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this title.

“PAYMENTS TO STATES

“SEC. 2002. (a)(1) Each State shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such 42 USC 1397a.

fiscal year, to be used by such State for services directed at the goals set forth in section 2001, subject to the requirements of this title.

“(2) For purposes of paragraph (1)—

Services.

“(A) services which are directed at the goals set forth in section 2001 include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

Expenditures.

“(B) expenditures for such services may include expenditures for—

“(i) administration (including planning and evaluation);

“(ii) personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

“(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1954 or to individuals with social services expertise, or through financial assistance to individuals participating in such conferences, workshops, and training or retraining (and this clause shall apply with respect to all persons involved in the delivery of such services).

26 USC 501.

“(b) The Secretary shall make payments in accordance with section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213) to each State from its allotment for use under this title.

“(c) Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.

“(d) A State may transfer up to 10 percent of its allotment under section 2003 for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or low-income home energy assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this title shall be treated as if they were paid to the State under this title but shall not affect the computation of the State's allotment under this title. The State shall inform the Secretary of any such transfer of funds.

Technical assistance.

“(e) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this title.

“ALLOTMENTS

42 USC 1397b.

“SEC. 2003. (a) The allotment for any fiscal year to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same

ratio to the amount specified in subsection (c) as the amount which was specified for allocation to the particular jurisdiction involved for the fiscal year 1981 under section 2002(a)(2)(C) of this Act (as in effect prior to the enactment of this section) bore to \$2,900,000,000.

94 Stat. 525.
42 USC 1397a.

“(b) The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

“(1) the amount specified in subsection (c), reduced by

“(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a),

as the population of that State bears to the population of all the States as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated (subject to subsection (d)) prior to the first day of the third month of the preceding fiscal year.

“(c) The amount specified for purposes of subsections (a) and (b) shall be—

“(1) \$2,400,000,000 for the fiscal year 1982;

“(2) \$2,450,000,000 for the fiscal year 1983;

“(3) \$2,500,000,000 for the fiscal year 1984;

“(4) \$2,600,000,000 for the fiscal year 1985; and

“(5) \$2,700,000,000 for the fiscal year 1986 or any succeeding fiscal year.

“(d) The determination and promulgation required by subsection (b) with respect to the fiscal year 1982 shall be made as soon as possible after the enactment of the Omnibus Budget Reconciliation Act of 1981.

Ante, p. 357.

“STATE ADMINISTRATION

“SEC. 2004. Prior to expenditure by a State of payments made to it under section 2002 for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this title, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this title, and any revision shall be subject to the requirements of the previous sentence.

Public report.
42 USC 1397c.

“LIMITATIONS ON USE OF GRANTS

“SEC. 2005. (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

42 USC 1397d.

“(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

“(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

"(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

"(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

"(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

"(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

"(7) for any child day care services unless such services meet applicable standards of State and local law; or

"(8) for the provision of cash payments as a service (except as otherwise provided in this section).

Waiver.

"(b) The Secretary may waive the limitation contained in subsection (a) (1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

"REPORTS AND AUDITS

42 USC 1397e.

"SEC. 2006. (a) Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this title. Reports shall be in such form, contain such information, and be of such frequency (but not less often than every two years) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 2004. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

Copies.

"(b) Each State shall, not less often than every two years, audit its expenditures from amounts received (or transferred for use) under this title. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this title, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this title, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

Unexpended funds.

"(c) For other provisions requiring States to account for Federal grants, see section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212).

"CHILD DAY CARE SERVICES

"SEC. 2007. (a) Subject to subsection (b), sums granted by a State to a qualified provider of child day care services (as defined in subsection (c)) to assist such provider in meeting its work incentive program expenses (as defined in subsection (c)) with respect to individuals employed in jobs related to the provision of child day care services in one or more child day care facilities of such provider, shall be deemed for purposes of section 2002 to constitute expenditures made by the State in accordance with the provisions of this title for the provision of child day care services.

Grants to
qualified
provider.
42 USC 1397f.

"(b) The provisions of subsection (a) shall not be applicable with respect to any grant made to a particular qualified provider of child day care services to the extent that (as determined by the Secretary) such grant is or will be used to pay wages to any employee at an annual rate in excess of \$6,000, in the case of a public or nonprofit private provider, or at an annual rate in excess of \$5,000, or to pay more than 80 percent of the wages of any employee, in the case of any other provider.

"(c) For purposes of this subsection—

Definitions.

"(1) the term 'qualified provider of child day care services', when used in reference to a recipient of a grant by a State, includes a provider of such services only if, of the total number of children receiving such services from such provider in the facility with respect to which the grant is made, at least 20 percent thereof have some or all of the costs for the child day care services so furnished to them by such provider paid for under a program conducted pursuant to this title; and

"(2) the term 'work incentive program expenses' means expenses of a qualified provider of child day care services which constitute work incentive program expenses as defined in section 50B(a)(1) of the Internal Revenue Code of 1954, or which would constitute work incentive program expenses as so defined if the provider were a taxpayer entitled to a credit (with respect to the wages involved) under section 40 of such Code."

26 USC 50B.

26 USC 40.
42 USC 1301.
Ante, p. 867.

(b) Section 1101(a)(1) of such Act is amended by adding at the end thereof the following new sentence: "Such term when used in title XX also includes the Virgin Islands, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands."

CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 2353. (a)(1) Section 3(a) of the Social Security Act is amended—

42 USC 303.

(A) by amending paragraph (4) to read as follows:

"(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

"(B) one-half of the remainder of such expenditures."; and
(B) by striking out paragraph (5).

42 USC 303.

(2) Section 3(c) of such Act is repealed.

42 USC 602 note.

(b)(1) Sections 402(a)(5), 402(a)(13), 402(a)(14), 402(a)(15) 403(a)(3), 403(e), and 406(d) of such Act as in effect with respect to Puerto Rico, Guam, and the Virgin Islands are repealed.

42 USC 602 note.

(2) Sections 402(a)(5), 402(a)(15), and 403(a)(3) of such Act as they apply to the fifty States and the District of Columbia shall be applicable to Puerto Rico, Guam, and the Virgin Islands.

42 USC 603 note.

(3) Section 248(b) of the Social Security Amendments of 1967 (Public Law 90-248) is repealed.

42 USC 602.

(c) Section 402(a)(15) of such Act is amended—

(1) by striking out “as part of the program of the State for the provision of services under title XX”; and

(2) by striking out “or clause (14)”.

42 USC 603.

(d) Section 403(a)(3) of such Act is amended by striking out “service described in section 2002(a)(1)” and inserting in lieu thereof “service described in section 2002(a)”.

42 USC 1203.

(e)(1) Section 1003(a) of such Act is amended—

(A) by amending paragraph (3) to read as follows:

“(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

“(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

“(B) one-half of the remainder of such expenditures.”; and

(B) by striking out paragraph (4).

(2) Section 1003(c) of such Act is repealed.

42 USC 1308.

(f) Section 1108(a) of such Act is amended in the matter preceding paragraph (1) to read as follows:

“(a) The total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, and under parts A and E of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—”.

42 USC 301,
1201, 1351, 1381,
601, 670.

94 Stat. 501.

42 USC 1315.

(g) Section 1115(a) of such Act is amended—

(1) in the matter preceding paragraph (1), by striking out “XIX, or XX” and inserting in lieu thereof “or XIX”;

(2) in paragraph (1), by striking out “1902, 2002, 2003, or 2004” and inserting in lieu thereof “or 1902”; and

(3) in paragraph (2)—

(A) by striking out “1903, or 2002” and inserting in lieu thereof “or 1903”, and

(B) by striking out “or expenditures with respect to which payment shall be made under section 2002,”.

42 USC 1316.

(h) Section 1116 of such Act is amended—

(1) in subsections (a)(1) and (b), by striking out “XIX, or XX” and inserting in lieu thereof “or XIX”;

(2) in subsection (a)(3), by striking out “1904, or 2003” and inserting in lieu thereof “or 1904”; and

(3) in subsection (d), by striking out “XIX, XX” and inserting in lieu thereof “or XIX”.

42 USC 1320a-3.

(i) Section 1124(a) of such Act is amended—

(1) in paragraph (1), by striking out “XIX and XX” each place it appears and inserting in lieu thereof “and XIX”; and

(2) in paragraph (2)—

(A) by inserting “or” after the semicolon at the end of subparagraph (B);

(B) by striking out “; or” at the end of subparagraph (C) and inserting in lieu thereof a period; and

(C) by striking out subparagraph (D).

(j) Section 1126(a) of such Act is amended by striking out “XIX, and XX” and inserting in lieu thereof “and XIX”. 42 USC 1320a-5.

(k) Section 1128(a) of such Act is amended—

(1) in paragraph (2)(A), by striking out “or title XX,”; and 94 Stat. 2619.

(2) in paragraph (2)(B), by striking out “or title XX”. 42 USC 1320a-7.

(l)(1) Section 1403(a) of such Act is amended—

42 USC 1353.

(A) by amending paragraph (3) to read as follows:

“(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and official administration of the State plan—

“(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

“(B) one-half of the remainder of such expenditures.”; and

(B) by striking out paragraph (4).

(2) Section 1403(c) of such Act is repealed.

(m)(1) Section 1601 of such Act is amended—

42 USC 1381
note.

(A) by inserting “and” before “(b)” the first time it appears; and

(B) by striking out “and (c)” and all that follows through “self-care,”.

(2) Section 1603(a) of such Act is amended—

42 USC 1383
note.

(A) by inserting “and” after the semicolon at the end of paragraph (2)(B);

(B) by amending paragraph (4) to read as follows:

“(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

“(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

“(B) one-half of the remainder of such expenditures.”; and

(C) by striking out paragraph (5).

(3) Section 1603(c) of such Act is repealed.

(n) Section 1616(e)(2) of such Act is amended by striking out “, as a part of the services program planning procedures established pursuant to section 2004 of this Act,”. 42 USC 1382e.

(o) Section 1619 of such Act is amended—

94 Stat. 445.
42 USC 1382h.

(1) by striking out “titles XIX and XX” each place it appears and inserting in lieu thereof “title XIX”, and

(2) by striking out “title XIX or XX” and inserting in lieu thereof “title XIX”.

94 Stat. 446.
42 USC 1382i.

42 USC 607.

Ante, p. 846.

(p) Section 1620(c) of such Act is amended by striking out the matter following the end of paragraph (7).

(q) Section 407(d)(1) of such Act is amended by striking out “a community work and training program under section 409 or any other work and training program subject to the limitations in section 409, or” and inserting in lieu thereof “a community work experience program under section 409, or”.

42 USC 671.

(r) Section 471(a)(10) of such Act is amended by striking out “standards referred to in section 2003(d)(1)(F)” and inserting in lieu thereof “standards in effect in the State with respect to child day care services under title XX”.

42 USC 1397a
note.

(s) Section 3(f) of the Social Security Amendments of 1974 (Public Law 93-647) is repealed.

EFFECTIVE DATE

42 USC 1397
note.

SEC. 2354. Except as otherwise explicitly provided, the provisions of this subtitle, and the repeals and amendments made by this subtitle, shall become effective on October 1, 1981.

STUDY OF STATE SOCIAL SERVICE PROGRAMS

42 USC 1397
note.

SEC. 2355. The Secretary of Health and Human Services shall conduct a study to identify criteria and mechanisms which may be useful for the States in assessing the effectiveness and efficiency of the State social service programs carried out with funds made available under title XX of the Social Security Act. The study shall include consideration of Federal incentive payments as an option in rewarding States having high performance social service programs. The Secretary shall report the results of such study to the Congress within one year after the date of the enactment of this Act.

Ante, p. 867.

Report to
Congress.

TITLE XXIV—UNEMPLOYMENT COMPENSATION

ELIMINATION OF NATIONAL TRIGGER

SEC. 2401. (a) GENERAL RULE.—Paragraphs (1) and (2) of section 203(a) of the Federal-State Extended Unemployment Compensation Act of 1970 are amended to read as follows:

26 USC 3304
note.

“(1) shall begin with the third week after the first week for which there is a State ‘on’ indicator; and

“(2) shall end with the third week after the first week for which there is a State ‘off’ indicator.”.

(b) TECHNICAL AMENDMENTS.—

(1) Section 203 of such Act is amended by striking out subsection (d) and by redesignating subsections (e) and (f) as subsections (d) and (e), respectively.

(2) Subparagraph (B) of section 203(b)(1) of such Act is amended by striking out “by reason of a State ‘on’ indicator”.

(3) Paragraph (2) of section 203(b) of such Act is amended by striking out “(or all the States)”.

(4) Subsection (e) of section 203 of such Act (as redesignated by paragraph (1)) is amended—

INTEREST ON LOANS MADE TO STATE UNEMPLOYMENT FUNDS

SEC. 2407. (a) GENERAL RULE.—Section 1202 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 1322.

“(b)(1) Except as otherwise provided in this subsection, each State shall pay interest on any advance made to such State under section 1201. Interest so payable with respect to periods during any calendar year shall be at the rate determined under paragraph (4) for such calendar year. 42 USC 1321.

“(2) No interest shall be required to be paid under paragraph (1) with respect to any advance made during any calendar year if—

“(A) such advance is repaid in full before the close of September 30 of the calendar year in which the advance was made, and

“(B) no other advance was made to such State under section 1201 during such calendar year and after the date on which the repayment of the advance was completed.

“(3)(A) Interest payable under paragraph (1) which was attributable to periods during any fiscal year shall be paid by the State to the Secretary of the Treasury not later than the first day of the following fiscal year. If interest is payable under paragraph (1) on any advance (hereinafter in this subparagraph referred to as the ‘first advance’) by reason of another advance made to such State after September 30 of the calendar year in which the first advance was made, interest on such first advance attributable to periods before such September 30 shall be paid not later than the day after the date on which the other advance was made.

“(B) Notwithstanding subparagraph (A), in the case of any advance made during the last 5 months of any fiscal year, interest on such advance attributable to periods during such fiscal year shall not be required to be paid before the last day of the succeeding taxable year. Any interest the time for payment of which is deferred by the preceding sentence shall bear interest in the same manner as if it were an advance made on the day on which it would have been required to be paid but for this subparagraph.

“(4) The interest rate determined under this paragraph with respect to any calendar year is a percentage (but not in excess of 10 percent) determined by dividing—

“(A) the aggregate amount credited under section 904(e) to State accounts on the last day of the last calendar quarter of the immediately preceding calendar year, by 42 USC 1104.

“(B) the aggregate of the average daily balances of the State accounts for such quarter as determined under section 904(e).

“(5) Interest required to be paid under paragraph (1) shall not be paid (directly or indirectly) by a State from amounts in its unemployment fund. If the Secretary of Labor determines that any State action results in the paying of such interest directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) from such unemployment fund, the Secretary of Labor shall not certify such State’s unemployment compensation law under section 3304 of the Internal Revenue Code of 1954. Such noncertification shall be made in accordance with section 3304(c) of such Code. 26 USC 3304.

“(6)(A) For purposes of paragraph (2), any voluntary repayment shall be applied against advances made under section 1201 on the last made first repaid basis. Any other repayment of such an advance shall be applied against advances on a first made first repaid basis.

“(B) For purposes of this paragraph, the term ‘voluntary repayment’ means any repayment made under subsection (a). “Voluntary repayment.”

“(7) This subsection shall only apply to advances made on or after April 1, 1982, and before January 1, 1988.”

(b) TECHNICAL AMENDMENTS.—

42 USC 1321.

(1) Paragraph (1) of section 1201 of the Social Security Act is amended by striking out “without interest” and inserting in lieu thereof “with interest to the extent provided in section 1202(b)”.

42 USC 1322.

(2) Section 1202 of such Act is amended by striking out “SEC. 1202.” and inserting in lieu thereof “SEC. 1202. (a)”.

CERTIFICATION OF STATE UNEMPLOYMENT LAWS; EFFECTIVE DATES

26 USC 3304.

SEC. 2408. (a) GENERAL RULE.—Section 3304(c) of the Internal Revenue Code of 1954 is amended by striking out the last two sentences and inserting in lieu thereof the following: “On October 31 of any taxable year, the Secretary of Labor shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by law to be included therein (including provisions relating to the Federal-State Extended Unemployment Compensation Act of 1970 (or any amendments thereto) as required under subsection (a)(11)), or has, with respect to the twelve-month period ending on such October 31, failed to comply substantially with any such provision.”.

26 USC 3304
note.

26 USC 3304
note.

(b) TRANSITIONAL RULES.—

(1) Except as otherwise provided in paragraph (2)—

(A) The amendments made by sections 2401 and 2402 shall be required to be included in State unemployment compensation laws for purposes of certifications under section 3304(c) of the Internal Revenue Code of 1954 on October 31 of any taxable year after 1980; and

(B) the amendments made by sections 2403 and 2404 shall be required to be included in such laws for purposes of such certifications on October 31 of any taxable year after 1981.

(2)(A) In the case of any State the legislature of which—

(i) does not meet in a session which begins after the date of the enactment of this Act and prior to September 1, 1981, and

(ii) if in session on the date of the enactment of this Act, does not remain in session for a period of at least 25 calendar days,

the date “1980” in paragraph (1)(A) shall be deemed to be “1981”.

(B) In the case of any State the legislature of which—

(i) does not meet in a session which begins after the date of the enactment of this Act and prior to September 1, 1982, and

(ii) if in session on the date of the enactment of this Act, does not remain in session for a period of at least 25 calendar days,

the date “1981” in paragraph (1)(B) shall be deemed to be “1982”.

No material relating to the Social Security Act in Volume I.

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3982

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO
SECTION 3 OF THE FIRST CONCURRENT RESOLUTION ON
THE BUDGET FOR FISCAL YEARS 1982, 1983, AND 1984

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY
VIEWS



[R-2]

VOL. II

JUNE 19, 1981.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1981

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OMNIBUS RECONCILIATION ACT OF 1981

JUNE 19, 1981.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

Mr. JONES, from the Committee on the Budget,
submitted the following

R E P O R T

[To accompany H.R. 3982]

[Including cost estimates of the Congressional Budget Office]

I. LEGISLATIVE BACKGROUND

The Subcommittee on Health and the Environment held a hearing on the report of the Select Panel for the Promotion of Child Health: 1980 on April 3, 1981. The Subcommittee held hearings on the Administration's Health Program Amendments of 1981 on April 6 and April 7, 1981.

Legislation to consolidate Federal assistance to the States for health services, H.R. 3224, was introduced by Mr. Madigan and Mr. Broyhill on April 10, 1981. Legislation to consolidate Federal assistance to States for maternal and child health and related services, H.R. 3732, was introduced by Mr. Waxman and Mr. Leland on May 28, 1981.

The Subcommittee on Health and the Environment considered H.R. 3732 on June 3, 1981 and ordered the bill reported, with amendments by voice vote.

II. SUMMARY OF LEGISLATION

The Committee proposal would consolidate a number of categorical and formula grant authorities relating to maternal and child health into a block grant, administered by the States, under which funds would be targetted on the provision of health services to mothers and children. The programs proposed for consolidation are the maternal and child health (MCH) and crippled children's services (CC) programs under Title V of the Social Security Act; the counseling and referral program for disabled children under 16 receiving Supplemental Security Income (SSI) case benefits authorized at section 1615 of the Social Security Act; the lead-based paint poisoning prevention program authorized at section 316 of the Public Health Service Act; the Sudden Infant Death Syndrome (SIDS) programs authorized at section 1121 of the PHS Act; the funding for hemophilia treatment centers authorized by section 1131 of the PHS Act; and the Adolescent Pregnancy program authorized by Title IV of the Health Services and Centers Amendments of 1978 (P.L. 95-626).

The new maternal and child health block grant would be authorized at Title V of the Social Security Act. States would have the discretion to apply funds allotted to them under the block grant to a wide range of maternal and child health related services. The Secretary of the Department of Health and Human Services would continue to administer the funding of various research, training, and related activities of regional and national scope.

III. BACKGROUND FOR PROPOSAL

Under current law, a number of categorical and formal grant programs finance the delivery of services to mothers and children or fund related training and research activities. The following programs would be consolidated under the Committees proposal:

Title V was authorized by Congress in 1935 (P.L. 74-271), and represents the Federal Government's oldest commitment to maternal and child health care. The program currently authorizes formula and discretionary grants to enable each State to extend and improve services for reducing infant mortality and otherwise promote the health of mothers and children, especially in rural and economically depressed areas. States are required to designate a single State agency for Maternal and Child Health (MCH) and/or Crippled Children's (CC) services, usually the health agency, to develop a State plan to extend and expand title V services and to supervise the utilization of Federal and State funds in the implementation of this plan.

Title V agencies provide two general types of services, MCH services and CC services, through the formula program. MCH services include general health services such as primary and preventive health care for mothers and children, and comprehensive services in designated areas through a "program of projects." Under the program of projects, States are required to develop a project in each of five areas: maternity and infant care, children and youth, family planning, dental health, and intensive infant care. CC services include (1) medical, surgical, corrective, and other services; and (2) facilities for diagnosis, hospitalization, and aftercare for crippled children and children with potentially handicapping conditions.

Under the current program, about 90 percent of title V's appropriation is required to be made available for MCH and CC services. One-half of this appropriation is apportioned by formula under a Fund A, the other half under a Fund B. Most of these funds represent grants to States, and are awarded to State Health agencies and/or CC agencies.

For both MCH and CC services, Fund A monies are allotted by formula for the States and require a dollar-for-dollar match. In each fiscal year, a State is allotted for MCH and CC services a basic grant of \$70,000 and an additional amount intended to reflect relative need based on child population and live births. For MCH Fund A, the additional amount is distributed in proportion to the number of live births in each State. For CC Fund A, the additional amount is based on the number of children under 21 years of age in each State.

Fund B monies carry no match requirement. In each fiscal year, \$10 million is allocated from Fund B for MCH and CC services for States and institutions of higher learning to establish projects to serve the mentally retarded. Of the remainder, at least 75 percent is allocated to States on the basis of State per *capita* income and either the number of live births (MCH) or the number of children under 21 (CC), with rural births and children given twice the weight of urban births and children. These funds are intended to assist States in carrying out their State plans. The remaining 25 percent or less, known generally as "Reserve B" or "RB" Funds, is retained at the Federal level for discretionary grants for special projects of regional or national significance.

Ten percent of the title V appropriation is earmarked for research and training. Five percent of the MCH appropriation can be transferred from formula funds, at the request of the Secretary of Health and Human Services (HHS), to be applied to research or training. In addition, the law requires that at least 6 percent of the title V appropriation be used for family planning activities.

Persons served by MCH Programs in 1980 included:

Women receiving physician maternity services	397,000
Women receiving nursing maternity services	522,000
Women receiving nurse midwifery maternity services	53,000
Women receiving family planning services	419,000
Children receiving physician services	2,789,000
Children receiving nursing services	5,598,000
Children receiving dental services	1,669,000
Infants admitted to intensive care	75,000
Preschool children assessments	1,070,000

Persons served by CC Programs in FY 1980 included:

Crippled children inpatient services	99,000
Crippled children basic and specialty assessment services	766,000
Crippled children ambulatory care services	535,000

An estimated 210,000 children under age 16 are estimated to be receiving Supplemental Security Income (SSI) cash benefits. This SSI-disabled children program provides services to about 70,000 of these children. Section 1615 of the Social Security Act authorizes formula grants to the States to provide counseling, development of individualized service plans, and referral for service for disabled children under age 16; and medical, social, developmental, and rehabilitative services for disabled children under age 7 who have never attended public school. During FY 1979, 48 States and the District of Columbia participated in the program.

Childhood lead toxicity afflicts about 1 percent of the 17 million children aged 1 to 5 years of age in the United States. Children living in older homes acquire lead-based paint poisoning by eating chips of paint made with lead. This problem is particularly prevalent in older inner city areas. Adverse effects of ingesting too much lead include blindness, seizure disorders, mental retardation, behavioral disorders, and death. Section 316 of Title III of the PHS Act provides funds for identifying children exposed to lead-based paint poisoning, ensuring prompt treatment for afflicted children, public education efforts on the danger and prevalence of lead-based paint poisoning, and identifying and reducing lead-based paint hazards in and around dwelling units. The Centers for Disease Control also provide proficiency testing services for laboratories involved in

analyzing blood for lead poisoning. During FY 1980, DHHS funded 59 project grants to provide lead-based paint poisoning prevention programs in communities. In 1980, the program reported grantees screening about 490,000 children and identifying about 35,900 with lead toxicity. Many of these identified children receive health care and treatment through the MCH and CC programs.

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of an apparently healthy infant which cannot be explained by a thorough post-mortem examination, or autopsy. Title XI, Part B of the PHS Act currently authorizes several SIDS activities including: (1) the creation of a coordinated and comprehensive system of services for survivors of SIDS victims, including case identification, the certification and prompt notification of the family about the cause of death and the provision of counseling support; (2) the collection and analysis of data gathered by the SIDS Information and Counseling project grantees; and (3) the development and dissemination of accurate and current information and educational materials for various professional and paraprofessional personnel as well as for the general public. As of October 1, 1980, 42 SIDS projects covered 34 States and the District of Columbia entirely and parts of 2 other States. Approximately 5,500 families received counseling under this program.

Hemophilia is a lifelong inherited blood clotting deficiency transmitted by women to their sons. Title XI, Part C of the Public Health Service (PHS) Act currently authorizes grants and contracts for projects to establish comprehensive hemophilia diagnostic and treatment centers which serve large geographic areas that may encompass more than one State. These centers provide (1) services for all hemophiliacs residing in the center's geographical area; (2) training of professional and support personnel in hemophilia research, diagnosis, and treatment; (3) counseling to hemophiliacs and their families; and (4) individualized written comprehensive care programs for each individual treated by or in association with

the center. During FY 1980, the Department of HHS funded 24 hemophilia diagnostic and treatment centers in 16 States. These centers serve about 6,000 persons annually. Services within this program are closely integrated with the title V program.

An estimated 1 million teenagers become pregnant each year. Title VI of the Health Services and Centers Amendments of 1978 (P.L. 95-626) authorizes grants to programs that provide services to adolescent parents and pregnant adolescents. Grant recipients are required to provide certain "core services," including pregnancy testing, family planning services, health services, family life and sex education services, and referrals for venereal disease screening and treatment, pediatric care, educational and vocational services, and adoption services. In addition, grantees may offer "supplemental services," including child care, transportation, consumer education, and counseling for family members. In FY 1980, DHHS awarded 23 new grants and 4 continuation grants to provide these services.

The following chart lists authorization/appropriation figures for these programs for fiscal years 1979-81.

TABLE 1. Funding History

Program	FY 1979 Author./Approp.	FY 1980 Author./Approp.	FY 1981 Author./Approp.
MCH.....	\$399,864,200	\$377,677,000	\$399,864,200
SSI-Disabled Children.....	30,000,000	30,000,000	30,000,000
Lead-Based Paint Poisoning Prevention.....	14,000,000	14,000,000	15,000,000
SIDS.....	3,500,000	2,802,000	7,000,000
Hemophilia.....	4,000,000	3,000,000	6,000,000
Adolescent Pregnancy.....	50,000,000	1,000,000*	75,000,000
Total.....	\$501,364,200	\$424,729,000	\$532,864,200

* Supplemental.

Source: Information provided by the Office of Maternal and Child Health, Health Services Administration, DHHS, with the exception of the Lead-Based Paint Poisoning Prevention and Adolescent Pregnancy Programs. Information on these programs was provided by Environmental Health Services, Centers for Disease Control, DHHS, and the Office of the Assistant Secretary for Health, DHHS, respectively.

IV COMMITTEE PROPOSAL

A. Program Consolidation

The Committee proposal would repeal the current Title V MCH and CC programs and replace them with a Title V maternal and child health block grant. The Committee recognizes the substantial contribution made by the various programs proposed for consolidation in helping to reduce the Nation's infant mortality rate and otherwise improve the health status of women and children. According to the testimony presented to the Subcommittee on Health and the Environment, there is substantial evidence that the 40 percent decline in infant mortality rates that has occurred since 1965 is associated with the advent of title V's Maternity and Infant Care (M&I) and Children and Youth (C&Y) centers and other program expansions, Community Health Centers, Medicaid, family planning support, and nutrition programs, as well as advances in newborn and intensive care.

However, despite these improvements, the Committee believes that much more needs to be done to improve health care for women and children. In its January 1980 report, Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome, the General Accounting Office (GAO) noted that: many areas of the Nation continue to experience excessively high infant mortality rates; non-whites experience substantially higher infant mortality than whites; the percentage of all infants born alive with low birth weight has not changed substantially since 1950 and the percentage of non-white infants born alive with low birth weight has not improved. In addition, many women receive inadequate prenatal care, many areas lack trained professionals to provide MCH services, and women in some areas can not get hospital care for labor and delivery services because they can not pay for it.

The Committee has heard testimony criticizing block grants as political devices for elimination of Federal health efforts. While this may well be the design of some proposals, it is not the intent of the Committee's proposal.

The Committee stresses that its proposal is intended to improve, not diminish, health care for mothers and children. The Committee expects that the consolidation of separate but related maternal and child health programs will lead to the development within States of a more systematic and comprehensive approach to providing health care to mothers and children, and particularly low-income mothers and children.

Many areas now lack systematic approaches for dealing with the unique health care needs of this population. The Committee believes this situation may be attributed in part to the fact that many separate categorical programs have evolved over a long period to address specific problems or population groups without benefit of a comprehensive, long-range plan. As a result, gaps exist in and between their services to mothers and children; fragmentation and duplication occur in both programs and services; and conflicts often develop among various levels of government administering these programs. The Committee intends that the consolidation of programs contemplated by its proposal will remedy these structural problems so that scarce Federal health funds can be more effectively focussed on services to mothers and children.

Current law sets forth the purposes of the title V program as broad mandates. These include the provision of services for reducing infant mortality and otherwise promoting the health of mothers and children, and the provision of services for locating, diagnosing and treating children who are crippled or who are suffering from conditions leading to crippling. The sweeping language of these provisions has not provided States with adequate guidance in fashioning their maternal and child health and crippled children's programs. In consolidating a number of related programs into a new Title V maternal and child health block grant, the Committee has sought to provide a more detailed description of the services states should provide. Specifically, section 501(a)(1) of the Committee proposal authorizes States to use grant funds to reduce infant mortality; to reduce the

incidence of preventable diseases and handicapping conditions among low-income children; increase the availability of prenatal, delivery, and post-partum care to low-income women; increase the number of children appropriately immunized; increase the number of low-income children receiving health assessments and follow-up diagnostic and treatment services; provide medically necessary services to handicapped children; and to carry out any of the purposes for which funds were applied under the programs consolidated into the new Title V block grant.

These purposes build upon the range of activities which most state health agencies currently provide. Information collected during Fiscal Year 1979 by the National Public Health Program Reporting System indicates that all State health agencies provided some level of maternal and child health services, as well as public health nursing and nutrition care and services for handicapped children. There are, however, significant variations in the amount of care provided by state health agencies. The Committee hopes that a more careful legislative description of the services which may be funded under Title V will encourage States that do not currently provide maternal and child health services to increase the scope of their programs. The Committee also hopes that States, in taking steps to assure that primary and prenatal services are actually more available to mothers and children, will provide community education and outreach to inform families about the availability of care.

The Committee proposal emphasizes the provision of health care to low-income mothers and children. These are among the most vulnerable elements of the population and tend to have the greatest need for the health services authorized by this proposal. The Subcommittee on Health and the Environment heard testimony from members of the Select Panel for the Promotion of Child Health pointing out a strong negative correlation between low family income and the timely receipt of both preventive health services and acute care services, as a combined result of financial barriers and the absence of accessible providers. One consequence of this is that in 1977, children

under 6 years in the poorest families had almost twice as many bed disability days as those in the highest income category, and a third more restricted activity days. The Committee hopes that States will give special consideration in the allocation of funds and design of their program to the needs of this population.

B. Allotments to States

The committee proposal authorizes the appropriation of \$394 million for Title V in FY 1982. This authorization would be increased by a percentage equal to half the percentage increase in the Consumer Price Index in each subsequent fiscal year. The proposal requires the Secretary of Health and Human Services (HHS) to reserve 15 percent of this amount for special projects of regional or national significance, research and training programs, multi-state regional resource centers, and comprehensive hemophilia diagnostic and treatment centers. The remaining 85 percent would be distributed among the States according to each State's relative share of the FY 1980 expenditures for all programs consolidated (including funds received by public or private entities within the State as well as by the State itself). If the amounts available for allotment to States in a fiscal year exceed the total amounts disbursed under certain designated programs in FY 1980, the difference would be distributed among the States based upon their relative share of low-income children in all States.

Under the committee proposal, States would be required to match the Federal funds allotted to them on a dollar-for-dollar basis. This matching requirement is intended to assure that States maintain a financial commitment to the provision of maternal and child health services.

The Committee recognizes the need to develop a formula that will more equitably distribute Federal maternal and child health funds among the States. Therefore, Section 509(b)(2) of the Committee proposal directs the Secretary, in consultation with the Comptroller General, to devise a new formula for equitably distributing these funds under this program and

report to Congress on it not later than January 1, 1983. This formula should take into account (1) the number of live births in the States, (2) the number of handicapped children in the States, (3) the number of low-income mothers and children in the States, (4) the financial resources of the various States, and (5) the populations of the States.

C. Use of Grant Funds by States

Under the Committee proposal, States may use Federal funds for a broad array of maternal and child health services. There are certain purposes for which these funds may not be applied. Under section 504(b), States are prohibited from using grant funds for any of the following purposes: (1) purchase of inpatient services (other than those provided to handicapped children and such other categories as the Secretary may by regulation provide); (2) making cash payments to intended recipients of health services; (3) the purchase or improvement of land; the purchase, construction, or permanent improvement (other than minor remodeling) of buildings or facilities; the purchase of major medical equipment; and the funding of depreciation or interest expenses connected with such purchases; (4) satisfying any requirement to spend non-Federal funds as a condition for the receipt of Federal funds; or (5) providing financial assistance to any private for-profit entity.

The purpose of these restrictions, as well as requirement of section 504(c)(3), is to assure that, to the maximum extent possible consistent with local needs, scarce Federal health resources are applied to the provision of primary and preventive services to mothers and children. While inpatient hospital services are obviously of great importance to handicapped children and high-risk maternity cases, the Committee is concerned that these high-cost services not absorb a disproportionate share of the limited funding under this block grant. The Committee expects that the Secretary, in defining the circumstances under which, and the levels at which, payment can be made for inpatient hospital services, will address this concern.

The Committee recognizes the large contributions local health departments have made to the improvement of maternal and child health care under the current Title V program. Accordingly, section 505 requires that States pass one third of these funds allotted to them on to localities. Political subdivisions receiving such funds would, of course be subject to all of the conditions and requirements applicable to the States under this Title and related laws.

Section 504(c)(2) of the Committee proposal requires that at least 85 percent of the funds allotted to States be applied to the direct provision of health services. Special consideration must be given (where appropriate) to the continuation of the funding of special projects previously funded under the Title V "program of projects".

For nearly 20 years, the Federal government has either administered or funded special health service projects of regional or national significance which show promise of contributing to the advancement of maternal and child health. These projects have included Maternity and Infant Care, Children and Youth, and dental projects, which since 1963 have provided comprehensive health care to millions of disadvantaged mothers and children throughout the nation. They have also included such special projects as Improved Pregnancy Outcome and Improved Child Health Outcome project grants, which have provided States with additional resources to improve the health status of mothers and children.

Since 1974, Maternity and Infant Care, Children and Youth and dental projects (known as the programs of projects) have been administered by the States through their Title V Maternal and Child Health formula grants. Federal law currently requires that as a condition of receiving Title V funds, state Title V plans include at least one of each of the above 3 programs of projects, as well as an intensive infant care project for high risk infants and a family planning project. Federal reporting data indicate:

that during fiscal 1979 these projects served more than 1.5 million mothers and children, nearly all of whom were severely economically disadvantaged and residing in seriously medically underserved areas of the country. Studies of the projects have noted their significant contribution to states' efforts to reduce maternal and infant mortality.

Although the Committee's proposal no longer requires States to maintain such projects as a condition of federal financial participation, the Committee does intend that States continue to fund current project service sites. The Committee recognizes that large Federal budget cuts will seriously strain States' ability to maintain funding for the programs of projects at adequate levels. The Committee proposal therefore authorizes the Secretary to use a portion of the 15% set-aside funds under section 502(a) to assist those States that are experiencing difficulty maintaining their "programs of projects". The Committee further anticipates that the Secretary will use a portion of the set-aside funds to maintain other projects of regional and national significance, including the Improved Pregnancy Outcome and Improved Child Health Outcome projects.

Under section 504(c)(3) of the Committee proposal, States must invest a reasonable proportion of funds on the services specified under section 501(a)(1) through (a) (5).

The Committee views adequate funding for primary and prenatal health services (including the programs of projects) as an absolutely essential component of any state's Title V program. The percentage of funds which States allocate to such services should approximate the percentage of all federal Title V grants to states that are currently invested in maternal and child health services. Presently, Title V appropriations include a specific earmark to States for maternal and child health services. This earmark, which in 1979 accounted for some 70% of all Title V grants to States, has assured that States spend a reasonable amount of funds on primary and prenatal care. The Committee intends that this emphasis on primary health

care be preserved.

In the Committee's view, family planning is fundamental to the health and well-being of women and children and, therefore, is an essential component of a comprehensive maternal and child health program. Evidence presented to the Subcommittee on Health indicates that infant mortality, low birth weight and stillbirths can be reduced through counseling and family planning. To date, the Title V Maternal and Child Health program has made a significant contribution to the provisions of family planning services, nationwide, especially to older women, spending an estimated \$20 million for family planning in 1979. The Committee intends that States continue to give priority to family planning services under this Title.

Section 505 of the Committee's proposal requires States to submit, for each fiscal year, a description of how they intend to use payments they receive, including information on the types of activities they will support, the categories of individuals to be served and the data which the states intend to collect regarding their activities. States must also provide assurances that their program activities are based on a needs assessment which takes into account health care needs of medically underserved populations, areas and localities. Furthermore, States must provide assurances that they have a method for fairly allocating federally allotted funds among the populations, areas and localities in need.

The Committee has included these provisions in its proposal in order to assure that limited resources are allocated in ways that best meet the actual health needs of disadvantaged mothers and children in each State. Evidence supplied to the Subcommittee on Health and the Environment points to a large amount of unmet maternal and child health need (especially for primary and prenatal care), an often inequitable distribution of available funds, and inadequate planning activities.

The Committee anticipates that States will develop Title V services, by first assessing mothers' and children's need for primary and specialized treatment care through a process that allows for public input; second, by determining the resources that are currently available to meet those needs; and third, by allocating available funds in a manner that assures that populations and localities in need are fairly served by the program. For example, if 10 counties in a State do not have prenatal services for low-income expectant mothers, the Committee anticipates that a State will attempt to make maximum use of available funds so that mothers in as many counties as

possible can be reached. The Committee believes that States can make maximum use of their funds by fully utilizing both public and private providers (including private non-profit organizations such as Community and Migrant Health Centers) in developing their Title V programs.

Under the Committee proposal, States may impose charges for the provision of maternal and child health services. However, if they elect to do so, section 505(2)(D) requires that they establish, and make public at all Title V provider locations, a schedule of fees that is adjusted for income, resources, and family size. No charge may be imposed upon mothers or children with incomes below the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually. The Committee expects that States, in establishing such fee schedules, develop fair and rational methods for determining a family's available income that take into account at least work-related and medical expenses.

The Committee is concerned about the deterrent effect that cost-sharing requirements have on the use of essential health services by low-income families. The Subcommittee on Health heard extensive testimony that cost-sharing obligations, especially for primary care services, substantially impede access to preventive health services and ultimately result in significant increases in acute health problems and utilization of more costly acute-care services.

In order to encourage low-income mothers and children to seek necessary health care in timely fashion, the Committee proposal exempts entirely from cost-sharing requirements persons whose income falls below official poverty guidelines. Furthermore, families above the poverty guidelines who cannot afford the full cost of necessary health care and who depend on Title V providers for health services, should be required to share in the costs of such care only in accordance with their ability to pay, given their net income and family size.

The Committee recognizes that a number of the services provided under this Act are confidential in nature and that some individuals (particularly adolescents) may be deterred from seeking assistance if they fear their confidentiality may be violated. Therefore, while the Committee believes that, as a general rule, fees for service (where they are charged) should be based on the income and resources of the family, rather than of an individual family member, it urges discretion in establishing fees so that individuals will not be denied needed care on the grounds that they hesitate to ascertain the family income. The Committee does not intend that fees become a barrier to service.

Because funds available to States under the new Title V will be limited, the Committee expects that States will not apply them to cases in which a mother or a child has public or private third-party coverage. To the extent possible, limited Title V funds should be preserved to finance care for low-income mothers and children who are not entitled to Medicaid or private insurance benefits.

Under section 505(2)(E), a State must give assurances that it will develop, and apply to all Title V providers of primary and prenatal health care services, guidelines which establish the appropriate frequency and content of health assessments for expectant mothers, infants, children and youth. Such guidelines should be developed in accordance with accepted standards of medical and dental practice, through consultation with members of the medical and dental community. They must also include standards outlining appropriate referral and follow-up care. In addition, the State must make arrangements to assure the quality of the services provided with funds under this title.

The Committee anticipates that the development and application of uniform maternal and child health assessment and follow-up guidelines will allow states to substantially improve the quality of their Title V programs. The Committee further expects that state Title V agencies will coordinate the frequency and content of their pediatric assessment schedules with those established by state Medicaid agencies for the Early and Periodic Screening Diagnosis and Treatment program. In this way, costly and duplicative screenings

will be avoided, and participation in the EPSDT program by Title V providers will be facilitated.

D. Accountability

Under the Committee's proposal, the States will enjoy substantial discretion to use the funds allotted to them for maternal and child health services. However, the Committee wishes to emphasize that the funds so allotted are still Federal, and that they may not be spent in a manner inconsistent with Federal requirements. The Committee proposal contains a number of provisions intended to assure State accountability for the use of these funds.

Section 506(a) requires States to submit annual reports to the Secretary on their maternal and child health activities. The reports must be in a form prescribed by the Secretary and contain the information needed to permit comparison and evaluation of relative State performance in achieving the purposes of this Title. Copies of such reports must be public.

Title V has often been criticized in the past for its lack of program accountability, due to the limited information on program accomplishments and use of funds. For example, in its January 1980 report on Federal efforts to reduce infant mortality, GAO pointed out that little was known about the extent to which state MCH programs were accomplishing program objectives.

GAO's findings were confirmed by the Select Panel for the Promotion of Child Health, which expressed strong concern about this problem.

The Committee places strong emphasis on the need for adequate and accurate State reporting. The Committee believes that information provided by these reports will be essential for evaluating the new Title V program nationally, documenting program accomplishments, justifying requests for appropriations, and identifying problems which may require technical assistance from the Secretary. To minimize the reporting burden, the Committee encourages

States to rely on existing data systems to the extent practicable.

To ensure that the purposes of Title V are efficiently and effectively met, adequate controls and monitoring must exist to (1) prevent and detect fraud, abuse, and illegal expenditures and acts; (2) identify inefficient practices; and (3) measure program effectiveness. Accordingly, section 506(b) requires an annual audit of State and local expenditures of funds allotted under Title V in accordance with the Comptroller General's Standards for Audit of Government Organizations, Programs, Activities, and Functions. These standards incorporate the American Institute of Certified Public Accountants' statement on auditing standards for field work and reporting, and include additional standards and requirements for government financial and compliance audits. Of equal importance, these standards provide for reviews of economy and efficiency of operations and effectiveness in achieving program results.

GAO's standards make clear that not every audit engagement requires all three elements of audits - (1) financial and compliance, (2) economy and efficiency, and (3) program results.

However, the Committee is concerned about each of the three general audit areas specified by GAO and expects to be a principal user of such audit findings. Accordingly, the Committee expects the States to arrange for audits that will include an examination of systems of internal control, systems established to ensure compliance with laws and regulations affecting the expenditure of Federal funds, financial transactions and accounts, and financial statements and reports in accordance with this title, applicable OMB circulars and applicable portions of the GAO audit standards.

The Committee recognizes that audits of economy and efficiency and program results for all aspects of a State's activities under this bill will most likely not be feasible on an annual cycle. However, the Committee expects that arrangements for such audits will be made on a regular basis.

In addition to independent audits at the State level, the Committee expects the Department's Inspector General and GAO, under their basic

legislative responsibilities, to audit and evaluate the operations and activities conducted by the Secretary and the States under this Title. The Committee also expects that GAO will study various aspects of the program when requested to do so by the Congress.

Section 507 of the Committee proposal establishes criminal penalties of up to \$25,000 in fines or 5 years imprisonment, or both, for those convicted of making false statements in order to defraud a State of funds allotted to it under Title V. In addition, Section 202 of the Committee's proposed Medicare and Medicaid Reconciliation Amendments of 1981 provides for civil money penalties for persons presenting false claims to States under Title V as well as Titles XVIII and XIX of the Social Security Act.

The Committee believes that these civil and criminal penalty provisions are essential to deter fraud and abuse under Title V and to clarify Federal jurisdiction in instances in which false statements or representations are made or a person intentionally conceals or fails to disclose such an event in connection with Federal funds allotted to States under the Title.

The Committee expects that every reasonable effort will be made by the States and the Secretary to prevent and detect misuse of Federal funds allotted under this title. Moreover, the Committee expects the Secretary, through the Department's Inspector General to work closely with the GAO and the Department of Justice to ensure that the program's vulnerability to fraud is assessed, weaknesses in controls are corrected, fraudulent acts are detected, and persons responsible for fraudulent activities are subjected to appropriate sanctions.

E. Nondiscrimination

Section 508 of the Committee proposal provides that any program or activity receiving any funds under the new Title V authority either directly or indirectly, is subject to the nondiscrimination provisions codified in the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and Title VI of the Civil Rights Act of 1964. In addition, the proposal prohibits all recipients of funds under this Title from discriminating on the ground of sex or religion. Whenever the Secretary of the Department of Health and Human Services, has made a finding of discrimination on the part of any entity that has received funds under this program, he is required to notify the chief executive officer of the State and to request him to secure compliance. If that official has not secured compliance within sixty days, the Secretary is authorized to take remedial action. Finally, the Attorney General is authorized to bring a civil action in any appropriate district court of the United States for such relief as may be appropriate to remedy any discrimination prohibited under this section.

The Committee intends that all entities that receive any funds under Title V, whether directly or indirectly, comply fully with the applicable nondiscrimination statutes and their implementing regulations. This includes any grantees or contractors to whom the Secretary has made funds available, as well as the States and their grantees and contractors that are funded, in whole or in part, by funds made available under Title V. With respect to discrimination on the basis of race, color, or national origin, the Committee intends that Title VI of the Civil Rights Act of 1964 and its

implementing regulations will provide the standards, enforcement mechanisms, and procedures applicable to entities assisted under this program. The Committee emphasizes that such entities may not engage in any kind of prohibited discrimination, whether direct or indirect, nor expend funds or allocate services in such a manner that persons of a particular race, color, or national origin group are disproportionately and adversely affected.

With respect to discrimination on the basis of handicap, the Committee intends that Section 504 and its implementing regulations will govern. The Committee is particularly concerned that services provided by recipients under this new Title be accessible to handicapped persons. For example, the Committee expects that services will be available in buildings that are accessible to persons confined to wheelchairs, and that appropriate auxiliary aids will be provided such that persons with hearing, visual, or speech impairments may receive effective services.

It is this Committee's specific intent that all aspects of a program or activity funded under Title V are to be operated in a nondiscriminatory manner, including all employment practices, regardless of the designated use of the federal funds in question. All of the remedies available under Title VII of the Civil Rights Act of 1964 shall similarly be available to remedy discrimination under Title VI, Section 504, Title IX, and 508(a)(2).

For purposes of implementing 508(a)(2), which prohibits discrimination on the ground of sex or religion, the Committee expects that the Secretary will promulgate, within six months after enactment, regulations which are consistent with those promulgated under Title VI, Section 504, and the Age Discrimination Act.

The Committee has placed primary enforcement responsibility for all of the nondiscrimination provisions set forth in this section with the Secretary

of HHS. However, the Committee intends to enhance civil rights compliance efforts by involving the Governors of the States in the process of securing compliance. In determining whether an entity has failed to comply with a law referred to in 508(a)(1) or (a)(2) and applicable regulations, the Secretary shall make a finding based on a prompt investigation following receipt of a complaint or the initiation of a compliance review. Of course, the Secretary may delegate within the Department the authority to conduct an investigation and make a finding. Following an investigation by the Secretary in which he finds that an entity that has received payments under this Title has violated any of the applicable nondiscrimination provisions, and after the Secretary has notified the entity in writing of its finding, the Secretary shall notify the chief executive officer of the state. The officer will then have a reasonable time, not to exceed sixty days, to secure compliance by way of a negotiated corrective action plan. The Committee intends that such corrective action plans be subject to the approval of the Secretary to ensure that all noncompliance with the civil rights provisions has been adequately remedied.

If the state's executive officer is unsuccessful in securing compliance within the sixty day period, the Secretary has a number of options set forth in section 508(b)(2). The Committee does not intend, however, to preclude the right of any individual to bring suit in Federal District Court to seek a remedy for any alleged discrimination, nor would exhaustion of administrative remedies be required.

The Committee expects that all recipients and sub-recipients of funding under this Title will provide assurances to the Department, consistent with the reporting and audit requirements imposed under this Title, that they will operate in compliance with Section 508, and that they will take steps to

ensure that all sub-recipients operate in a nondiscriminatory manner.

The Committee also expects that the Attorney General, under Section 508(c), will take prompt action on cases referred to the Department of Justice.

F. Federal Set-Aside

The Committee proposal provides that 15% of appropriated funds be retained at the Federal level to allow support for:

- 1) projects of regional and national significance in maternal and child health care;
- 2) support for hemophilia diagnostic and treatment centers;
- 3) education and training activities;
- 4) research and evaluation.

The government has traditionally had a strong role in supporting special projects of regional or national significance which have developed new knowledge about the causes and treatment of maternal and child health and translated this knowledge into accepted methods of health care delivery and treatment. The Committee has been favorably impressed by the progress made under the Secretary's special initiatives to improve pregnancy outcome and child health.

Substantial support for university affiliated facilities to carry out research activities related to mental retardation and maternal and child morbidity has come from the Federal level. Special training activities have been supported. For example, in Alabama, funds were used to train nurses to deal with the special situation of high-risk infants in rural areas where special facilities might not be immediately available. Further, under current law, the hemophilia program has provided support for diagnostic and treatment centers whose catchment area extends beyond state lines.

The Committee believes that continuation of these activities is essential. It believes they can be carried out in the most cost effective manner if they are supported at the Federal level. Duplication of research can be avoided. Dissemination of results can be most easily accomplished. Further, the Com-

mittee believes it is both likely and appropriate that States will concentrate their maternal and child health funds on service programs. Retaining reasonable funding at the Federal level to target on research, training and special project activity is warranted.

Training is clearly necessary to the conduct of good maternal and child health programs, and support for it is almost necessarily required at the Federal level. Skills required to administer the health programs embraced in Title V are not synonymous with clinical expertise. Additional preparation focusing on population-level considerations, program planning, management and evaluation are not part of clinical specialist preparation whether it be medicine, nursing, social work or other health professions that provide clinical care to mothers and children. Schools offering this graduate education and training are not in every state, and attention to the specific needs in administering maternal and child health programs are included in only some of the established schools.

Any given state cannot be expected to support this training beyond those occasions when it has a vacancy. Support to develop such training programs, and to have them maintained for training those individuals any state wishes to have so prepared, must come from the national level rather than states. Such training represents a national resource and should be so supported.

Research and special projects also pay great dividends. Progress in bettering maternal and child health and lowering infant mortality justify a continuing commitment of Federal dollars. The outstanding work of the UAF's in bettering the health of mothers and children and in dealing with problems of the mentally retarded is widely acknowledged.

The Committee also has placed special responsibility for supporting hemophilia centers at the Federal level. While individual States may also choose to direct some of their funds to this area, generally hemophilia centers are regional in nature, and support will be more efficiently carried out from the Federal level. The Committee intends that the Secretary continue the regional centers, and the system of regionalization, insofar as possible, and that the Secretary continue the Federal coordination necessary for the program's integrity.

The Committee notes that hemophilia treatment is one of the biomedical and medical success stories of the decade. Research findings on blood clotting factors, leading to many possible improvements in care, were brought to the patient in remarkably short time. The legislation enacted in 1975 permitted core funding which now permits these thousands of young hemophiliacs, who would otherwise be severely crippled by their teen years, and probably die at a young age, to live essentially normal lives.

Under section 504(e), the Secretary may not make funds available under the 15% Federal set-aside unless he has received assurances from an applicant that funds will be used only for authorized and intended purposes, and that appropriate fiscal control and accounting procedures will be established to assure proper disbursement and accounting of such funds.

The Committee expects the Secretary to prescribe, arrange for, and carry out appropriate audits, evaluations, and other administrative measures to ensure that set-aside funds contribute to the advancement of maternal and child health in an efficient, economical, and effective manner. The Committee further expects the Secretary to apply appropriate fund award and reporting procedures to provide for objective review of applications for funds and reasonable assurance that program objectives are being achieved.

V. PROGRAM OVERSIGHT

On May 16, 1979, the Subcommittee on Health and the Environment held an oversight hearing on the gaps in existing Federal health programs for children (Printed, Ser. No. 96-14). On April 3, 1981, the Subcommittee held a hearing on the Report of the Select Panel for the Promotion of Child Health, Better Health for Our Children: A National Strategy.

Legislative Background

Instructions to reduce funding in the entitlement or direct spending programs within the jurisdiction of the Committee on Energy and Commerce were received under the First Budget Resolution. Background material clarified the expectation that outlays in the Medicaid program would be reduced by approximately \$900 million in FY 1982. The Committee on Energy and Commerce also has jurisdiction over Part B of title XVIII (Medicare), which is also a health financing program paid for through general revenues (and premium contributions). The Committee's action reduces spending in both of these health care financing programs.

Summary of Legislation

The bill is designed to reduce Federal outlays in Medicaid by over \$900 million in FY 1982 (with continuing savings in the next two fiscal years) in a manner which spreads the loss equitably among the States and which provides the States with flexibility to institute a number of measures in their programs to reduce cost and make them more efficient. Measures to reduce Federal expenditures in Part B of Medicare are also included.

The major provisions of the bill are:

(1) A reduction in Federal payments to the States of 3 percent in FY 1982, 2 percent in FY 1983, and 1 percent in FY 1984. The amount of the loss of Federal funds could be reduced by one-third for each of the following factors: (a) unemployment in excess of 150 percent of the national average, (b) existence of a qualified hospital cost review program, (c) demonstrated recoveries from fraud and abuse control and third party payment collections equal to at least 1 percent of Federal payments which would otherwise be due.

(2) Repeal of the requirement that States pay hospitals on the basis of reasonable cost as defined by Medicare. States could establish their own

reimbursement systems provided that rates were "reasonable and necessary to the efficient and economical delivery of services."

(3) Authority to use competitive bidding arrangements for the purchases of clinical laboratory services, medical devices and drugs. The freedom of choice of providers could be limited to those selected under the competitive bidding arrangements.

(4) Elimination of the penalty for failure to inform persons of the availability of EPSDT services, and to carry out related requirements.

(5) Waiver of certain Medicaid requirements to allow certain program arrangements designed to increase efficiency and effectiveness.

(6) Options to include home and community-based care services as alternatives to long-term institutional care, if arrangements to control total long-term care expenditures are satisfactory to the Secretary. A preadmission screening program for persons seeking nursing home or ICF care would be required.

(7) Various changes to remove unnecessarily restrictive Federal requirements or to provide States with greater flexibility.

(8) Elimination of Federal matching for excessive preoperative stays, tests which the physician did not order, and ineffective drugs.

(9) Provision for civil money penalties for providers who defraud the program.

(10) Changes to eliminate ineffective PSRO's, and to provide each State with the option to decide whether to use the PSRO.

(11) Adjustments to eliminate the carry-over provision in the Part B deductible and to index it.

(12) Limits on home health agency reimbursements.

(13) Changes in the renal dialysis program to allow incentive reimbursement and coverage of nutritional therapy.

(14) Other assorted provisions

Cost Impact

The estimated cost impact on Medicaid and Medicare Part B of the provisions included in the Committee proposal (and of the reductions in Medicaid costs occurring because of the restrictions on AFDC eligibility adopted by the Ways and Means Committee) is as follows:

Cost Impact - Reductions in Medicaid and Medicare Part B

Section	FY 1982		FY 1983		FY 1984	
	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare
Sec. 6321 (Reduction in Medicaid Payments of 3%)	-520	-26	-400	-90	-230	-149
Sec. 6322 (Release from reasonable cost)	-250		-280		-320	
Sec. 6323 (Competitive bidding)	-90		-110		-120	
Sec. 6324 (No longer require 18 to 21)	-10		-42		-44	
Sec. 6326 (Waivers)	*		*		*	
Sec. 6328 (Closure & Conversion)	---	-2	-2	-7	-4	-19
Sec. 6329 (LTC Preadm. Screening)	-20		-50		-60	
Sec. 6331 (No Federal Matching for Excess. Preop Stays)	-10		-14		-17	
Sec. 6336 (Elimination of Occup. Test for LTC Reimb. in Hosp)	-25	-80	-25	-85	-30	-105
Sec. 6337 (Civil Money Penalty)	-14	-7	-14	-7	-14	-7
Sec. 6341-6345 (PSRO's)	-17	-17	-18	-33	-36	-8
Medicaid Impact of AFSS Eligibility Changes			-55		-60	
Sec. 6346 (Carryover of Part B Deductible)	+4	-55	+4	-55		-55
Sec. 6347 (Index. of Part B Deductible)	+7	-90	+15	-215	+25	-330
Sec. 6348 (Incentive Reimbursement for Renal Dialysis)		-105		-130		-155
Sec. 6349 (Home Health Limits)		-12		-23		-27
Sec. 6350 (Nutritional Therapy)		-20		-25		-30
TOTAL	-971**	-414	-913**	-670	-890**	-886

*Minimal cost impact

**Does not add because of overlap of Section 6321 with other savings provisions

Background: Current Program

Medicaid, authorized under Title XIX of the Social Security Act, is a federally aided, State-administered program of medical assistance for certain categories of low-income persons. An estimated 21.7 million people received program services in FY80.

PROGRAM DESCRIPTION

Each State designs its own Medicaid program within certain Federal guidelines and requirements. Thus there is substantial variation among the States in eligibility requirements, range of services offered, limitations imposed on such services, and reimbursement policies. The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula that is periodically adjusted. The matching rate, which is inversely related to a State's per capita income, ranges from 50% to 83% (See Table 1). The Federal share of administrative costs is 50% except for certain items where the authorized rate is higher.

Eligibility

States having Medicaid programs must cover the "categorically needy." In general, categorically needy individuals are persons receiving cash assistance payments under the Aid to Families with Dependent Children program (AFDC) or aged, blind, or disabled persons receiving benefits under the Supplemental Security Income program (SSI). A State must cover under Medicaid all recipients of AFDC payments. A State is, however, provided certain options (based, in large measure, on its coverage levels in effect prior to implementation of SSI in 1974) in determining the extent of coverage for persons receiving Federal SSI benefits and/or State supplementary SSI payments. States may cover certain additional groups of persons as "categorically needy" under their Medicaid programs. These might include persons who would be eligible for cash assistance, except that they are patients in medical facilities (other than for persons under 65 who are in mental or tuberculosis institutions).

States may also include the "medically needy" -- those whose incomes and resources are large enough to cover daily living expenses, according to income levels set by the State, within certain limits, but not large enough to pay for medical care, providing that they are aged, blind, disabled, or members of families with children. States may also include all needy and medically needy children under the age of 21, even though they are not eligible for assistance under one of the cash assistance programs.

All States (except Arizona) and the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands, have Medicaid

programs. Twenty jurisdictions cover only the "categorically needy," while 34 cover both the "categorically needy" and the "medically needy."

Coverage limited to the Categorically Needy

Alabama	Georgia	Missouri	Oregon
Alaska	Idaho	Nevada	South Carolina
Colorado	Indiana	New Jersey	South Dakota
Delaware	Iowa	New Mexico	Texas
Florida	Mississippi	Ohio	Wyoming

Coverage Includes Both Categorically Needy and Medically Needy

Arkansas	Kentucky	New Hampshire	Rhode Island
California	Louisiana	New York	Tennessee
Connecticut	Maine	North Carolina	Utah
District of Columbia	Maryland	North Dakota	Vermont
Guam	Massachusetts	Northern Mariana Islands	Virgin Islands
	Michigan		Virginia
Hawaii	Minnesota	Oklahoma	Washington
Illinois	Montana	Pennsylvania	West Virginia
Kansas	Nebraska	Puerto Rico	Wisconsin

Services

Federal law requires States to include the following basic services in their Medicaid programs: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis and treatment services for individuals under 21. In addition, States may provide any number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

For both the mandatory and optional services, States may set limitations on the amount, duration, and scope of coverage (for example, a limitation on the number of days of hospital care or the number of physician visits).

Under current law, Medicaid recipients are permitted to obtain medical assistance from any institution, agency, community pharmacy, or person

qualified to perform the service if such individual or entity undertakes to provide it. This is known as the "freedom of choice" provision.

Payment for Services

States, in general, determine the reimbursement rate for services, except for inpatient hospital care, where they are required to use Medicare's reasonable cost payment system unless they have approval from the Secretary of Health and Human Services to use an alternative payment methodology. States are required to reimburse skilled nursing facilities and intermediate care facilities at rates that are reasonable and adequate to meet the cost that must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. Generally, for other services, States may establish their own reimbursement levies, provided the amounts do not exceed what would be allowed under Medicare. In many instances, the rates are considerably less.

Payments for covered services are made directly to the provider of services and the provider is required to accept the Medicaid payment as payment in full for covered services.

Cost-Sharing

Federal law permits States to impose nominal copayments and deductible amounts with respect to optional services for the categorically needy and for all services for the medically needy. In addition, nursing homes residents are required to turn over their excess income to help pay for the cost of their care; as a minimum they are allowed to retain \$25 for their personal needs.

TABLE 1
Federal medical assistance percentage by state

State	Effective: 10/1/79-9/30/81	Effective: 10/1/81-9/30/83
Alabama	71.32	71.13
Alaska	50.00	50.00
Arizona	--	--
Arkansas	72.87	72.16
California	50.00	50.00
Colorado	53.16	52.28
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	58.94	57.92
Georgia	66.76	66.28
Guam	50.00	50.00
Hawaii	50.00	50.00
Idaho	65.70	65.43
Illinois	50.00	50.00
Indiana	57.28	56.73
Iowa	56.57	55.35
Kansas	53.52	52.50
Kentucky	68.07	67.95
Louisiana	68.82	66.85
Maine	69.53	70.63
Maryland	50.00	50.00
Massachusetts	51.75	53.56
Michigan	50.00	50.00
Minnesota	55.64	54.39
Mississippi	77.55	77.36
Missouri	60.36	60.38
Montana	64.28	65.34
Nebraska	57.62	58.12
Nevada	50.00	50.00
New Hampshire	61.11	59.41
New Jersey	50.00	50.00
New Mexico	69.03	67.19
New York	50.00	50.88
North Carolina	67.64	67.81
North Dakota	61.44	62.11
Northern Mariana Islands	--	50.00
Ohio	55.10	55.10
Oklahoma	63.64	59.91
Oregon	55.66	52.81
Pennsylvania	55.14	56.78
Puerto Rico	50.00	50.00
Rhode Island	57.81	57.77
South Carolina	70.97	70.77
South Dakota	68.78	68.19
Tennessee	69.43	68.53
Texas	58.35	55.75
Utah	66.07	68.64
Vermont	68.40	68.59
Virgin Islands	50.00	50.00
Virginia	56.54	56.74
Washington	50.00	50.00
West Virginia	67.35	67.95
Wisconsin	57.95	58.02
Wyoming	50.00	50.00

Section 6321 - Reduction in Medicaid Payment
to the States

Under current law, Medicaid is financed jointly with State and Federal funds. The Federal government shares in the cost of each State's Medicaid program, with the Federal contribution determined under a statutory formula which is designed to have the Federal government pay a proportionally larger share of the program in poor States. The bill provides for a temporary pro rata reduction in the amount of Federal funds that will be provided to each State. In FY 1982, the Federal payment otherwise due to each State will be reduced by 3 percent, in FY 1983 by 2 percent, and in FY 1984 by 1 percent. In each year, a State which met certain specified conditions could reduce the amount of loss in Federal funds by one-third for each condition under which it qualified.

The Committee has recommended this decrease in Federal funding with reluctance. Medicaid is a program of health care directed to the very poor. It is a program which has already strapped State budgets. It is a program which States currently have every incentive to run efficiently and to hold down costs wherever possible. It is a program whose increases in cost have been accounted for almost entirely by inflation in medical care costs, particularly increases in hospital costs. The number of persons eligible has not increased significantly since the early 1970's. Utilization of services has remained nearly constant. The Committee has recommended the decrease in Federal funding for three reasons only: (1) the economic conditions in the country, and the response of the Congress to them, has mandated that a reduction in Federal spending be achieved, (2) this method of reduction provides an equitable and temporary way to spread the loss of Federal funding among the States, and (3) this method is clearly preferable to placing a "cap" on the Federal contribution which would be

arbitrary, inequitable, and a total change of the nature of the program.

The provision for the reduction in Federal payment works as follows: a State (and the Secretary) would determine the appropriate total Federal payment to the State under title XIX, including the Federal share of expenditures for medical services under the existing medical assistance matching rate and the Federal share of administrative costs under the existing administrative matching rates. This total amount would then be subject to the flat Federal reduction of 3 percent in FY 1982, 2 percent in FY 1983, and 1 percent in FY 1984, with whatever adjustments are appropriate if the State qualifies for a lessening of this amount because it meets any of the specified conditions. There would be no change in the basic matching rate formula, on either a temporary or a permanent basis.

While providing for a general 3 percent reduction in FY 1982 (and progressively smaller reductions thereafter), the Committee did believe that certain specific circumstances should allow a State to suffer less of a penalty. First, if a State has an unemployment rate that is at least 150 percent of the national average, the Committee believed the reduction in Federal funds should be reduced. States facing high unemployment are already disadvantaged in two ways: the State revenue base is reduced, making it more difficult for the State to meet its share of the cost of the program, and the number of persons eligible for Medicaid coverage is increased. For these reasons, the reduction in Federal funds is reduced by one-third if the State meets the unemployment test.

Secondly, where a State has established a State hospital rate review system, which applies to substantially all hospitals and to all payors (or all payors except Medicare, if the Secretary has not yet agreed to place Medicare under the system), and which meets certain standards of success,

the reduction in Federal funds is reduced by one-third. The Committee believes that if the State has taken these steps and lower Medicaid expenditures have resulted then the Federal expenditure has already been effectively reduced. The benefits of the lowered costs accrue both to the Federal government and to the States. A recent study by the Government Accounting Office of States which have hospital cost review programs in place indicates that such programs have had a significant impact on lowering the rate of inflation in both the cost of a hospital stay and the cost of a hospital day. Other recent research confirms these findings. The GAO study concluded that "the primary effect of prospective rate-setting programs has been improved hospital budgeting techniques and increased cost awareness by hospital personnel".

The Committee specifically intends that qualifying hospital cost review programs must be established by statute, be operated as State agencies, have jurisdiction over all non-Federal hospitals, and review all non-Medicare inpatient revenues or expenses or at least 75 percent of all revenues or expenses including those arising under Medicare. Six States would qualify on the basis of existing programs: Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington.

All qualifying programs must assure the Secretary that each entity which pays for hospital services, employees, and patients (including the Medicare and Medicaid programs) is provided substantially equal treatment with regard to the costs or rates approved by the State agency in each hospital.

The Committee specifically intends that in addition to meeting the above standards for program organization and operation, qualifying programs must demonstrate their ability to effect reductions in the rate of inflation

experienced. The effectiveness test focuses on Statewide per capita hospital spending. In the case of existing programs, the State must show that aggregate hospital inpatient costs per capita have risen at least 2 percentage points less (using a one, two or three year base) than the rate of inflation in all States without qualifying programs. In the case of new programs, the State must provide assurances that its rate of increase in hospital inpatient costs per capita will be less than 4 percent higher than the implicit price deflator for the Gross National Product for the projected fiscal year.

Finally, any State may lessen its reduction in Federal funds by one-third if it demonstrates to the satisfaction of the Secretary that the Federal matching funds it is entitled to receive have been reduced by at least one percent because of recoveries through fraud and abuse activities or because of third party payment collections. Generally, the intent of the Committee is that recoveries must be documented; claims of reduced expenditures because fraud and abuse has been "discouraged" would be considered too subjective to establish the right to a smaller reduction in Federal funding. However, in the case of third party payment collections, it is recognized that some States have organized their program in such a way that third party liabilities are established and collected prior to the State expenditure. While this is not technically a "recovery" of funds from a third party payor, it can be documented and the end result---a reduction in Medicaid payments--is the same. The Committee believes that States which are effective in carrying out these good management practices should be rewarded for their efforts. The Federal savings occur because of the one percent reduction in State claims for Federal matching funds; this substitutes for one-third of the flat reduction in Federal payments otherwise provided for under this section.

The Committee believes that if a drastic change in the Federal financial commitment to Medicaid is to be adopted, then such change should be undertaken only after careful consideration of the most appropriate ways to restructure the program. The Committee believes this savings proposal, in conjunction with other provisions of this bill, is sufficient to achieve an acceptable reduction in Federal spending on a clearly temporary basis while providing adequate time for a careful reexamination and restructuring of the Medicaid program.

Section 6322 - Hospital Reimbursement Rate Determination

This section eliminates the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid. The Committee bill requires instead that Medicaid payments be "reasonable and necessary to the efficient and economical delivery of services." In authorizing the States to develop alternatives to reasonable cost, the Committee bill recognizes the special circumstances of hospitals serving large proportions of Medicaid patients and patients without third party coverage. Further, the Committee bill requires that, by 1984, State Medicaid programs use a system under which payment amounts for hospitals are set on a prospective basis.

Under current law, State Medicaid programs must reimburse hospitals for their "reasonable costs" of treating Medicaid patients unless the Department of Health and Human Services approves the use of an alternative method. However, even the alternative methods approved by HHS generally must offer a reasonable cost basis for reimbursement. These requirements result in higher levels of inpatient hospital reimbursement than States might set if granted more flexibility. With States facing hospital cost escalation exceeding the rate of inflation and recent American Hospital Association data showing annual hospital cost increases of 20 percent, States could achieve significant savings in their Medicaid program by reducing hospital costs. If freed from the reasonable cost reimbursement criterion, States would likely develop hospital reimbursement systems which would incorporate tests of efficiency and prudent buyer requirements, and thereby lower costs.

In eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services. The Committee is especially interested in the development of prospective rate methodologies as a replacement for the current reasonable cost reimbursement system under Medicaid. However, in the interim period while prospective systems are under development, the Committee intends to provide the States with flexibility to implement alternative reimbursement systems to contain costs.

In permitting States greater flexibility in reimbursement system design, the Committee intends the States to ensure that such alternative systems provide fair and adequate compensation for services to Medicaid beneficiaries. The Committee intends that reimbursement levels for inpatient services must be adequate to assure that a sufficient number of facilities providing a sufficient amount of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to be able to obtain quality inpatient services for the treatment of their medical conditions. The Committee believes the payment levels should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals available in the State. The Committee would be extremely concerned to see a substantial reduction in hospitals' willingness to treat Medicaid patients as a result of payment policy changes.

The Committee believes that hospitals should be paid for the cost of

their care to Medicaid patients in the most economical manner. The Committee intends States to recognize that facilities that provide teaching services or other specialized tertiary care services that may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by the States recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services. For example, the Committee does not intend that the only facility providing a specific type of treatment, such as treatment of spinal cord injury, not be available to Medicaid beneficiaries because the State's payment level is inadequate to meet the basic cost of care in that facility.

Thus, while the Committee recognizes that in this time of economic constraint and reductions in Federal funds for Medicaid, States must be given the flexibility necessary to improve the Medicaid reimbursement mechanism, the Committee does not want such policies to result in arbitrary and unduly low reimbursement levels for hospital services. In several States, a significant differential exists between the Medicaid payment level for physicians and the rate paid by Medicare and private individuals for physician services. As a result, many physicians now refuse to treat Medicaid patients. The Committee is very concerned that a similar situation not develop with respect to hospital care.

The Committee is also concerned about the impact of the States payment practices on facilities that treat a large volume of Medicaid patients and patients who are not covered by other third party payors. The Committee intends that payment for inpatient services take into account the special costs of hospitals whose patient populations are disproportionately composed of such individuals.

Therefore, the Committee bill requires that States, in determining the appropriate reimbursement rate for inpatient hospital services, and in developing a prospective payment methodology, take into account the special costs of hospitals whose patient populations are disproportionately composed of individuals who are either provided medical assistance under the State plan or who have no source of third party payment for such services. Such hospitals, especially in urban areas, are often multi-faceted health care institutions, which provide many public health and social services to all residents of their area, in addition to serving as hospitals of last resort for the poor. Their sizeable Medicaid populations often require extra social and public health services. In addition, in many areas such hospitals also provide considerable care for indigent persons not eligible for Medicaid, who often have only partial or no health care coverage.

Nor do many such hospitals collect more than a small proportion of their overall revenues from non-public sources.

The Committee heard testimony, for example, that only 12 1/2 percent of the revenues of Cuyahoga County Hospital come from privately-insured or self-paying patients, while over 29 percent come from Medicaid, and over 21 percent from county tax appropriations. At Boston City Hospital, less than 10 percent comes from private patients, while 30 percent is Medicaid and over 39 percent is provided by local governments. (The Medicare share for these hospitals is 16 and 21 respectively). Finally, such hospitals often operate or coordinate many categorical health and social programs and will

thus suffer from proposed budget cuts in those areas as well. For these reasons, many such hospitals are now and will clearly continue to be financially distressed, and will experience special costs which States should take into consideration.

In determining whether a hospital's Medicaid and "free care" population is disproportionate, the Committee expects States to consider the proportion of such individuals in the hospital's patient population, compared to all hospitals in an area, as well as the proportion of a hospital's share of the total estimated number of such individuals in an area, as an appropriate basis for special consideration.

In implementing this provision, the Committee also intends States to take into account continuity of care for Medicaid patients and recognize the need to assure access to inpatient services in those facilities where a patient's physician has admitting privileges. The Committee is also concerned that hospitals with large outpatient departments be reimbursed at levels for inpatient care that permit active participation in the Medicaid program and will encourage continuity of care in the treatment of Medicaid beneficiaries.

The Committee intends that the Secretary move forward with the necessary research and methods to develop a system for paying hospitals based on the complexity and severity of the cases treated in each hospital. The Committee specifically provides that the development of methods for grouping hospitals on the basis of their mix of cases, considering the complexity and severity of patients treated, should be undertaken immediately. The Committee intends such a system to also take into account the special costs of hospitals whose patient populations are disproportionately composed of individuals who are on Medicaid or who have no source of third party payments for their care. The methodology to be developed by the Secretary

should also address appropriate adjustments to be made in the prospective rate when have substantial cost increases due to unforeseen changes in the rate of inflation or major changes in service mix. Consideration should also be given to the applicability of such a system to Medicare and other third party payors. The Secretary is to provide the Congress with a report on the development of the prospective system by March 31, 1982. In addition to describing the methodology and alternatives developed by HHS, this report should review the progress of the States in developing prospective reimbursement systems for their Medicaid programs and analyze the approaches taken by the various States. Moreover, the Committee intends the Secretary to analyze the impact of the reimbursement methodology on access to care for Medicaid beneficiaries, on differentials in payment levels between Medicare and Medicaid, and on the financial viability of institutions whose patient populations are disproportionately composed of Medicaid patients or patients without third party coverage. The Secretary should develop provisions in the rate methodology to assist such facilities and should assess the adequacy of such provisions in his report to the congress.

Competitive Arrangements for Payment
for Laboratory Services, Medical Devices and
Drugs (Section 6323)

Under current medicaid law, program eligibles are entitled to obtain covered services from the provider of their choice. This freedom of choice requirement poses a bar to State or local efforts to establish more cost effective arrangements for the purchase of laboratory services, drugs, and medical devices, where great economics might be realized if bulk purchasing or competitive bidding arrangements were used.

The Committee has concluded that the value of maintaining the freedom of choice concept for these particular services is outweighed by the cost savings States could achieve if they were allowed to secure these services through competitive bidding procedures or other similar arrangements, which may result in a limitation of the providers from which the individual could receive these services. However, the Committee believes these prudent buyer practices should be allowed only to the extent that adequate services are in fact available under these arrangements , and that the providers meet adequate quality standards and serve a population broader than the Medicaid population.

In regard to laboratory services, it is the Committee's view that competitive bidding arrangements are entirely appropriate. GAO and others have concluded that even though States are volume purchasers of laboratory services, they often pay higher prices for such services than other purchasers. Further, the individual does not select his "laboratory" provider in any real sense, since the services are not direct or initiated by the individual. Finally,

the fact that State Medicaid programs deal with large numbers of laboratories has often made the practical enforcement of laboratory quality standards more difficult.

The provision allows States (or parts thereof) to purchase laboratory services under arrangements which would not be subject to the general freedom of choice requirements of the medicaid law, provided that services would be purchased only from laboratories that met standards, and that the prices charged the program would not exceed the lowest amount generally charged to others for similar tests, or, if the purchasing arrangements were agreed to on some unit price basis, that the aggregate expenditures would not exceed the aggregate-expenditures that would have been anticipated if each test was charged at the lowest rate charged to others for that test. Additionally, the arrangement must provide that adequate laboratory services would be available to physicians and other providers treating medicaid patients.

The Committee is concerned, however, that concentration of medicaid business in a small number of laboratories might prove detrimental to quality if the laboratory served only the medicaid population. The Committee believes it would be beneficial to make arrangements for the purchase of services only with laboratories that provide services to both private and public patients. Providers of laboratory services to the general population have established fee schedules for their services and often have operational quality assurance mechanisms, thus providing the purchaser with a ready means of determining the lowest rate charged for quality services. The Committee does not wish to take any action which would result in the development of a two-class system of health care in this country by allowing States to purchase laboratory services from providers whose only customer is medicaid. Experience has generally shown that the existence of a private clientele has a quality assurance effect on the services provided to public patients. Therefore, the Committee has established as an additional condition for the purchase of laboratory services on a competitive or other limited basis that no more than 75 percent of the laboratory's business may be with medicaid and medicare patients.

The Committee recognizes that one result of this legislation will be a reduction in the number of providers from whom a State, or political subdivision, may purchase laboratory services. Theoretically, it would be possible for a State or political subdivision under this act to enter into arrangements with only one provider of laboratory services in an area (provided the condition of adequate available services was met). The Committee's intent, however, is not to encourage such a monopolistic situation in any large health care delivery area. Obviously, in such an area it is more desirable to encourage the utilization of several providers. If only one provider is serving a very large population group, the State could become the "captive" of the provider and find it administratively difficult to switch to another provider should the first prove to be inadequate or to charge excessive rates. In addition, accessibility of the services to the physician should be a consideration in determining the number of such arrangements. Therefore, it is the Committee's expectation that States making arrangements with providers of laboratory services under this legislation would generally not make such arrangements with only one provider of such services in any large health care delivery area.

In regard to medical devices and drugs, the Committee recognizes that greater concern exists that limiting the providers through which devices and drugs can be purchased may result in a severe reduction in the accessibility of the service. The Committee proposal gives States additional flexibility to administer their Medicaid programs in a more cost-effective manner. However, it is not the Committee's intent to change the basic requirement of current law that States make necessary medical services of reasonable quality truly available and accessible for the recipients. The Committee expects that, in exercising the discretion afforded by the Committee proposal, States will develop their plans carefully to assure that this requirement continues to be

met.

The Committee urges States to explore various purchasing arrangements whereby the cost economies can be realized without restricting the points at which the recipient can receive the medical device or the drug. Bulk purchasing or competitive bid arrangements would clearly be appropriate when the drugs or medical devices are provided to persons in nursing homes, for example. Further, bulk purchasing of drugs which could then be made available to recipients through numerous retail outlets may also serve to secure cost efficiencies for the State without reducing accessibility or availability of the service to the recipient. Also, the State may find it appropriate to provide coverage where any provider could meet the price which the State, negotiated through its own bulk purchase or competitive bidding arrangements. If a State does determine that restriction of providers is appropriate, the Committee emphasizes that the test of availability of quality services should be stringently enforced.

The Committee expects that where States adopt programs which limit the places where drugs or medical devices can be secured, they should make information available to recipients as to where the services are available. Additionally, where laboratory services are limited, physicians and clinics should also be so informed.

The Committee wishes to emphasize that States must continue to operate their programs in conformity with approved State plans. Plan changes that would affect the rights of Medicaid beneficiaries or participating providers would be subject to approval of the Secretary, who must confirm that the State's program will continue to be operated in a lawful manner. Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.

Elimination of EPSDT Penalty (Section 6324)

The Committee bill repeals the provision of the AFDC program that requires the Secretary to impose a penalty of 1% on the amount of federal AFDC payments to a state in the case of a state's failure to inform AFDC families about the EPSDT program or provide screening, diagnostic and treatment care to families who request services. The bill further specifies that, as a matter of compliance with the requirements of the Medicaid statute, states shall continue to be responsible for providing EPSDT outreach, medical and support services to all recipients under the age of 21 who have been determined to be eligible for Medicaid. States are expected to inform Medicaid-eligible children about EPSDT through their parents, or where appropriate, through the child's guardian or legally responsible relative.

The EPSDT program, enacted by Congress in 1967, requires states to take affirmative action to enroll children in ongoing preventive and primary health programs and to assure that children receive the services to which they are entitled. Those services include, at a minimum, comprehensive and periodic medical and dental assessments, vision, dental and hearing treatment services, and other treatment services, as provided under states' Medicaid plans. In order to satisfy the early and preventive requirements of the program, states must provide children with necessary support services (such as scheduling and transportation) to assure that children receive, in a prompt fashion, the assessment and treatment services they need.

From the program's inception in 1967, EPSDT has included a strong outreach component, designed to reach all Medicaid-eligible children. Congress contemplated that states would develop organized and intensified casefinding procedures which encouraged participation in preventive health care and recognized the limitations of written informing techniques.

In 1972, concerned by states' failure to fully implement EPSDT, Congress passed the AFDC penalty statute, Section 403(g) of the Social Security Act. The statute imposes an additional penalty of 1% on states' AFDC programs (in addition to any Medicaid penalty which might be imposed for states' failure to properly implement the EPSDT program) for failing to provide EPSDT to AFDC-eligible children. While Congress intended that all Medicaid-eligible children receive the full complement of EPSDT services, including informing and medical and support care, the 1972 AFDC amendments added the additional penalty only with respect to AFDC children because of the greater administrative ease in monitoring such children.

Experience with the penalty statute leads this Committee to conclude that the penalty has not had the desired effect of encouraging states to involve more children in the program.

Often the intent of providing preventive health assessment and treatment services effectively to poor children has been lost in "an unproductive" focus on highly complex documentation requirements in order to "prove" that no penalty should be assessed.

To maximize benefits and reduce administrative burdens on the states, the Committee recommends that the penalty be repealed, while clarifying that all underlying program requirements will be retained. The Committee expects that states will continue to provide EPSDT medical and administrative services to all

Medicaid-eligible children in a timely fashion in order to assure achievement of the purposes of the program. Further, it believes this action will give States the flexibility to carry out the program more effectively.

Section 6325. Repeal of Required Coverage for Individuals Aged 18 - 21

The bill would repeal the requirement in current law that States provide Medicaid coverage to persons aged 18-21 who would be eligible for AFDC cash assistance if they were attending school. States could, at their option, continue to provide coverage to this population and would receive Federal matching funds for such coverage.

The Committee considered various alternatives for the requirements concerning the age to which children must be covered. Current law requires only that children who are members of AFDC-type families be covered, but within that narrow framework, they must be covered if they receive AFDC (or would if they were in school) up to the age of 21. In determining the priorities for expenditure of funds, the Committee determined that in general a State should be required to cover a child only up to the age of 18. If a State includes in its AFDC program children up to 21, then the requirement of Medicaid law that all persons receiving AFDC payment be eligible for medical assistance would continue to govern. Thus, the minimum coverage group for children becomes, in the reported bill, children up to the age of 18 and children over 17 and under 21 to whom the State has, at its own option, provided an AFDC payment.

Eighteen States now provide Medicaid to all needy children under 21 who are determined to be needy regardless of whether the child is alone, is in a broken family, is in a family with an unemployed parent, or is in an intact family. It is not the intention of the Committee to require any reduction in coverage for this group. The Committee believes States should choose whether or not to cover this group when determining the priorities for expenditure of its funds under Medicaid. Therefore, the Committee believes States should be allowed to provide coverage for needy children up to the age

of 21 and Federal matching should be available for all medical assistance provided if a State elects this option. The Committee expects that if the State opts for this broader coverage, the children between 17 and 21 brought into coverage would be eligible for the same services and under the same conditions as children under 18 covered under the State plan.

The Committee was aware that some States might desire to extend coverage to certain groups of individuals over 17 and under 21 without including all such individuals. The intent of the Committee was to allow States to opt to cover all needy individuals under 21, or all needy individuals under 18 and reasonable classifications of individuals over 17 and under age 19, 20, or 21. The Committee believes this will allow States flexibility to target assistance on those most in need. However, to prevent arbitrary classifications which are difficult to administer and discriminate against groups of children, the Committee expects the reasonable classifications used by the States to include those categories currently used under Medicaid. These include, for example, children in foster care, children in psychiatric hospitals, and children in intermediate care facilities. Additionally, for example, the Committee would find reasonable a classification which allows coverage of those children between 17 and 21 who were covered by the State plan before enactment of this law, i.e., children between 18 and 21, in AFDC-type families who are not actually receiving an AFDC payment but would except for requirements of section 406(a)(2) of the Social Security Act.

Section 6326 - Waiver of Medicaid Requirements

This provision of the Committee bill authorizes the Secretary to waive those requirements of Medicaid law necessary to allow States to (1) implement a case-management system for primary care, (2) "lock" recipients who chronically overutilize services into a designated provider, (3) share with recipients any cost savings resulting from their use of more cost effective delivery systems such as HMOs, or (4) exclude from the program those providers that systematically abuse the program. In addition, the Secretary would be authorized to allow localities to act as central brokers in giving recipients a choice of competing health plans. A waiver request could not be approved if it would substantially impair access to services of adequate quality.

Under current law, States must design and manage their Medicaid programs in accordance with certain statutory requirements. These requirements define the types of care reimbursable by the Federal government through its matching to the States. While these requirements generally serve to insure that Federal funds for Medicaid are expended for appropriate services on behalf of Medicaid beneficiaries, the Committee recognizes that in some cases these requirements have hampered a State's ability to control costs. Under current law, States can apply to HHS for a waiver of provisions of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries. However, approval of such waivers is contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration.

Under the Committee's waiver provision, the Secretary would be given authority to grant waivers of Medicaid State plan requirements to the States

for the purpose of demonstrating improvements in the provision of services under Medicaid. The waiver process would be streamlined. If the Secretary does not deny a waiver request (or ask for further information to allow him to make a decision) within 90 days, the request would be deemed approved. Additionally, the research and evaluation criteria and the uniqueness of the approach required by the demonstration authority of current law would not be required under this authority. However, the Committee does intend the States to be able to document the cost-effectiveness and program impact of their desired changes. In granting the Secretary this broadened waiver authority, the Committee intends that the waiver authority only be used to approve waivers that assure access to care is maintained or improved for Medicaid beneficiaries. The Committee does not intend the Secretary to approve waivers which preclude the provision of an adequate amount of services or the availability of services during reasonable time periods and within reasonable geographic distance of the residence of the Medicaid beneficiaries.

The Committee bill authorizes the Secretary to grant waivers to States to restrict the provider from or through whom an individual eligible for Medicaid can obtain primary care services to the extent necessary to implement a case management system. The Committee believes the potential advantages of a case management system to promote coordinated and comprehensive care for Medicaid beneficiaries justify, on a demonstration basis, the restriction on freedom of choice of provider by the beneficiary. The Committee intends States to use the cost management approach to provide comprehensive and health care services to Medicaid beneficiaries in a more cost effective manner.

While it is recognized that some States are interested in extending this approach to the entire Medicaid population, the Committee notes that

this will only be feasible if an exceptionally high degree of provider participation is secured. To the extent that the system is not in effect for all beneficiaries, the Committee intends the beneficiaries to be offered a choice with regard to participation in the case management model.

The bill also provides for waivers of freedom of choice to allow a State to "lock-in" chronic overutilizers of service to a single physician or limited group of providers. The Committee recognizes that a small number of persons chronically abuse their Medicaid eligibility and overutilize services available to them; this increases program costs and undeservedly influences the way many Medicaid recipients are viewed. In fact, utilization of services by the Medicaid population is below the national average. But where abuses occur, a lock-in procedure may be appropriate. An individual subject to the lock-in arrangement, however, should be given an opportunity to change the provider he is locked into periodically (in no case less frequently than every three months). The Committee is concerned that such waivers apply only to those recipients that clearly and without doubt over-utilize services and that, in no event, should services from any certified provider be denied such recipient in the case of genuine emergency. Further, the Committee intends that the Secretary not agree to any waiver that results in substantially impairing access to necessary medical care for any recipient found to be over-utilizing specified services.

The bill also allows waivers for States to restrict the participation of providers in their Medicaid programs if, after notice and opportunity for hearing, the State determines that the provider, in a substantial number of cases, provided services to recipients when such services were not medically necessary or of a quality not meeting professionally-recognized standards of

health care. The Committee is concerned that some providers may furnish unnecessary services in order to maximize reimbursement under Title XIX or provide poor quality care and wants to enable States to penalize such providers. On the other hand, the Committee believes that access to quality health care for recipients is paramount and that the Secretary should not grant waivers that result in restrictions that substantially limit access to health care of adequate quality when medically necessary. The Committee is, of course, also concerned that such restrictions not limit geographic accessibility to necessary services for recipients.

Waivers may also be granted to allow a locality to act as a central broker in assisting recipients to select among competing health care plans. However, waivers should not be granted under this section that would, in any way, compromise access to quality health care for any individual who is in a position of selecting a competing health care plan.

The Committee has provided for waivers which would allow States to share (through direct payments or other services) with recipients of medical assistance under the State plan any cost savings resulted from the recipient's use of more cost-effective medical care and that such payment will not be treated as income or resources for purposes of eligibility for cash or medical assistance under any title of the Social Security Act. However, enticement of additional cash to encourage needy recipients to enter plans that are geographically or otherwise inaccessible or inconvenient to such recipients.

The Committee bill requires that a State request a continuation of its waiver after two years. At that time it should demonstrate that the waiver continues to achieve the goals set out for it. The waiver would continue unless the Secretary acted within 90 days to deny it or to receive further information. It should be clear, however, that any

waiver agreement can be withdrawn by the Secretary if he finds that it is not meeting the conditions set forth for it---if services are not available, if the conditions on the waiver are violated, etc. The Committee urges the Secretary to publish in the Federal Register summaries of the substance of all initial and continuation waiver requests.

The Committee makes special note that in no instance should any of these waiver authorities be applied in such a way as to limit access to emergency services. Further, while the Committee appreciates the need for States to realize economies in their Medicaid programs and desires, through waivers provided for in this section, to accord States with the flexibility to make such economies, the Committee is greatly concerned that such waivers are not to be used to substantially impair access to care for all recipients. Access to quality health care services that are sufficient in amount to meet genuine needs of all recipients should be maintained and services should be available from providers that are sufficient in number and location so as to be reasonably accessible to all recipients.

Section 6327. Removal of Medicare Reasonable Charge Limit

Under current law, State payments to physicians under Medicaid are not permitted to exceed the medicare "reasonable charge" level. The Committee bill repeals this provision and thus removes medicare reasonable charge levels as a ceiling on medicaid payments. The committee has taken this action to remove the administrative burdens this requirement of current law imposes on the States and to provide States with the flexibility to create incentives to improve the availability and utilization of physician services under medicaid.

The Committee believes the removal of the ceiling on physician payments based on medicare will not result in an increase in expenditures for physician services under medicaid. The States all face clear cost pressures in their medical programs. Therefore, the Committee expects this provision will be used by the States to improve the administration of their medicaid programs and to try innovative approaches to physician payment rather than merely to raise physician fees above medicare levels. The Committee believes removal of the medicare ceiling will help simplify the State's administration of the medicaid program. The Committee has heard reports of problems experienced by some States in obtaining the Medicare prevailing charge data in order to calculate their medicaid fee levels. Many of the procedures reimbursed under medicaid, such as pediatric services, are not covered under medicare. For such procedures, it is extremely difficult to establish a comparable medicare reasonable charge level to use as a ceiling for medicaid. Other problems arise in States where medicare has several payment localities. Under current law, States are unable to apply a single payment rate statewide unless that rate is set below the lowest reasonable charge level for a medicare locality.

In States with significant payment differentials between urban and rural areas under medicare, States must set their fees arbitrarily low to be under the ceiling Statewide. A 1975 HEW study showed a 23 percent fee differential between metropolitan and non-metropolitan areas under medicare. Under current law, the medicare ceiling could hamper development of a Statewide medicaid fee schedule, especially if such a schedule were to provide reimbursement above medicare levels in rural areas as a means of attracting additional physicians to such areas.

The Committee believes repeal of the medicare reasonable charge ceiling will allow States to be more creative and offer incentives for improved delivery of care under their programs. Medicare payment levels are a reflection of physician charge patterns in an area and thus build in historical biases. With the removal of medicare as an upper limit, States can structure their physician payment levels to build in incentives or bonuses for physicians who provide care in more cost effective arrangements. Moreover, States would be free to design their reimbursement systems to provide incentives for provision of primary care over specialty care or to reduce the urban-rural differential in payment levels.

PERMITTING MEDICAID MATCHING FOR PAYMENTS TO PROMOTE CLOSING
AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES
(Section 6328)

Under current law the Federal government will not match a state for any costs the State incurs by reimbursing hospitals for the costs of closing or converting underutilized hospital facilities. Because excess hospital beds and services can cause increased costs and require higher Medicaid and Medicare payments, the Committee wants to encourage States to develop programs to close or convert underutilized facilities.

The Committee's proposal would allow a state to include such costs for federal matching purposes, would allow a State to include in whatever methods it develops for paying hospitals an amount to assist in meeting the cost of eliminating or converting unneeded facilities, and would allow the total payments to a hospital to exceed the limit of Medicare's reasonable cost payment which would otherwise apply if they exceeded the limit because of the closure or conversion payment.

The Committee recognizes that in some circumstances it is inappropriate for the federal government to pay for hospital closures. When a hospital is located in or serves a medically underserved area or population, the State should not encourage its closure.

If a State has a statutory program which provides for an orderly and systematic process for identifying and changing underutilized facilities, and the federal government is matching closure and conversion payments to facilities, the program should provide tha

closures and conversions can not be carried out without fair and equitable arrangements to protect the employees of the facilities.

Hospitals and the supply and service industries which grow up around them are major employers, particularly of semi-skilled and unskilled workers, women and minorities. In inner city areas where hospitals are often the only significant employer closures and cutbacks have a deleterious effect on a population with limited opportunity for other employment.

In patterning the employee protections after section 1642(c) of the Health Planning Act, the Committee expects that hospitals receiving funds for closure and conversion will protect employers against a worsening of their positions respecting employment. The Committee intends that such protection will include maximum effort to secure substantially equivalent alternative employment, retraining programs where necessary to achieve the above, preservation of employee rights under collective-bargaining agreements, preservation of pension, health and other fringe benefits, and adequate severance pay if necessary.

The Committee does not intend to promote the closure, relocation or conversion of hospitals serving predominantly Medicaid recipients or persons without third party coverage. The Committee is concerned that the closure of such facilities, particularly public general hospitals, would severely undermine the access of low income individuals to needed services.

Sec. 6329 Options for the provision of home and community-based care and requirements of preadmission

Under current law, Medicaid provides little or no coverage for long-term care services in the community, while offering full or partial coverage for such care in an institution. The Committee is concerned that even though only approximately 6% of the elderly reside in institutions, more than 40% of Medicaid expenditures went for institutional care this year.

It has been estimated that a quarter of the current nursing home population does not need full-time, residential care. Many elderly, disabled and chronically ill persons live in institutions not for medical reasons, but because of the paucity of health and social services in their communities, and their inability to pay for those services or to have them covered by Medicaid when they do exist.

Assessment procedures required under Medicaid to determine the need for institutional care for the elderly and disabled have not been adequate in preventing avoidable admissions. Most of the reviews occur after admission to the long-term care facility, when it is most difficult to discharge the resident back to the community. In addition, the reviews focus on medical conditions primarily, and not on social and other factors which are often more critical in determining the most suitable placement.

The Subcommittee held several hearings on this issue during the 96th Congress; December 11, 1979 and May 30, June 10 and June 23, 1980. Witnesses representing the National Governors' Association, the Association of State Medicaid Directors, National Conference of State Legislators, along with representatives of all the major aging organizations, submitted testimony. Also presenting their views were organizations representing persons with chronic diseases, developmentally disabled persons,

representatives of the home health industry and the nursing home industry, professional and consumer organizations involved in long-term care, and others. All testified for the need for medicaid coverage of home care.

Last year, a bill was introduced (The Medicaid Community Care Act of 1980) which responded to this issue, and enjoyed the cosponsorship of over 130 House members. Sec. 6329 incorporates much of that bill.

The Committee believes this section goes a long way in addressing the issue of inappropriate institutionalization and the need for community-based services for the elderly and disabled.

Under the provisions of this section, states which elect to have home-based care covered by medicaid would be required to develop a community care plan subject to the approval of the Secretary. Under the plan, states would have to provide for a comprehensive assessment of all persons who are eligible or applying for medicaid coverage for care in a skilled nursing facility (SNF) or an intermediate care facility (ICF; ICF-MR). The assessment must be a direct and personal one, where the person performing the assessment actually sees and interviews the person applying for care.

This assessment should take place soon after application is made, and should be conducted by trained persons, preferably by a multi-disciplinary team of health and social service workers. This assessment must take into account all the factors, including family supports, community ties, and health and financial factors, relating to the need of the individual for long-term care in a SNF or ICF.

To avoid potential conflict of interest, this assessment, with certain exceptions, should not be conducted by persons or agencies who would benefit directly or indirectly from the results of the assessment. This would include persons or entities which have an ownership or controlling interest in, or contract with agencies or facilities which might provide services to persons as a result of the assessment. The Committee recognizes that in some states there are few trained health and social services personnel and facilities equipped to conduct assessments and provide care. To require a division of those functions in such underserved areas could impede the

development of home-based services and ultimately deny medicaid recipients alternatives to institutionalization. Therefore this section provides an exception in such areas.

The Committee has also made provision for exception on this point under other special circumstances that the Secretary may approve. This will allow limited Secretarial discretion in approving, for example, plans submitted by those States which have in place on a statewide or partial-state basis, a demonstration similar to the community care plan described in this section, where assessments currently are done by providers of care. Public entities, such as State or county health departments, also are eligible for the exceptions from this provision.

The purpose of the assessment for which no co-payment may be required of recipients, is to determine whether the recipient needs a level of care comparable to that provided in a SNF or ICF. The individual would be informed in writing of the determination and, if such a level of care is found to be necessary, be informed of all feasible alternatives and given the option of institutional or community-based, noninstitutional care.

The determination of what long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by the comprehensive assessment, and not short-term cost savings. While the Committee anticipates that the provision of community-based care will have a long range and significant impact on the size of states' Medicaid budgets, it does not believe that states should make decisions regarding feasibility of community-based care on the basis of whether or not such arrangements will produce short-term cost savings.

The Committee views the services under this section as a means of furthering established federal policy of deinstitutionalization and promoting access to community-based services, as evidenced by other federal programs, including the Developmental Disabilities Assistance and Bill of Rights Act.

In the event that an individual is aggrieved by the results of the assessment and its recommendation, the Committee expects that states will provide such persons with an opportunity to present additional medical and related evidence at a fair hearing. Since a finding that community-based services are not feasible in a particular case constitutes a denial of services covered under a state's Medicaid plan, the Medicaid statute requires that applicants and beneficiaries be provided with the procedural protections of the Medicaid administrative hearing process.

The Committee intends that with the expansion of services under this section there be no diminution or weakening of quality standards for long-term care services provided both in the community, and in institutions. In the case of services for the mentally retarded and the developmentally disabled, the Committee emphasizes the need for quality standards appropriate and specific to both the large and small ICF-MRs. Furthermore, providers of community services to residents of these facilities should coordinate their services with responsible staff of those facilities, to assure a continuity of care.

For persons determined to be in need of nursing home level of care who choose, instead, to remain in the community, the State would be required to provide for the development of a written plan of care describing the service needs of the individual and prescribing those services. The committee emphasizes that the ultimate choice about institutional placement rests with the patient and appropriate family members.

There is considerable variation among the States with respect to the organization of health and social services with respect to sophistication in dealing with long-term care, and other pertinent factors. Recognizing this, the Committee intends to allow States the greatest possible flexibility in establishing plans with respect to the comprehensive assessments, plans of care development, and the provision of services, with certain exceptions outlined above which are intended to prevent conflict-of-interest. For example, States could develop their plan for providing

community care in a number of ways. A State agency or agencies could conduct the comprehensive assessments, develop the plan of care, and provide the services. Or, the States could contract with private or public agencies to carry out some or all of these functions under proper licensure procedures. However, in order to assure the State Agency of adequate fiscal control, the plan of care required would be initially approved and reviewed periodically by the State. This function could also be carried out by contract.

The Committee intends for a wide variety of non-institutional services to be covered under this section. Often such services can be provided most efficiently and effectively by professionals, other than physicians, such as social workers and nurses, qualified mental retardation professionals, and by non-professionals

such as nurse's aides, homemakers, and personal care attendants. Under the plan of care, the level of personnel most appropriate for each service should be specified, and adequate and appropriate reimbursement should be provided.

The services authorized in this section include nursing, home health aide, personal care, medical supplies and equipment, physical and occupational therapy, and speech pathology and audiology. These may now be provided under Title XIX, and are defined in the Medicaid manual. Other services which the Committee intends to have covered are homemaker and adult day care, both defined in Title XX of the Social Security Act.

The Committee wishes to emphasize that adult day care encompasses both health and social services needed to insure the optimal functioning of the client, as well as habilitation services suitable for the care of the mentally retarded and the developmentally disabled.

Respite care is seen by the Committee as essential if families are to be supported in their efforts to care for vulnerable and dependent persons at home. Respite care services are those services given to an individual unable to care for him/herself on a full time basis, which are provided on a short-term basis to such individual because of the absence of or need for relief for those persons normally providing such care. Services can be offered in the home of an individual, or in an approved facility such as a hospital, a nursing home, a foster home, or a community residential facility.

In order for elderly and disabled persons to benefit from the services covered in this section, the Committee recognizes the need for a case management system, under which responsibility for locating, coordinating and monitoring long term care services in behalf of a recipient rests with a defined person or agency. It is the Committee's intent that the case manager be responsible for locating available sources of help from within the family and the community, so that

the burden of care will not be exclusively borne by formal health and social agencies. The "informal network" of friends, relatives, churches, clubs, etc., should be used wherever feasible to strengthen the elderly or disabled person's ties with his own community.

Because the needs of recipients of long-term care services are varied and complex, the Committee intends for the States to have flexibility in deciding which community-based services are most relevant. Therefore, under this section, States would be allowed, with Secretarial approval, to provide additional services, not listed here, which would aid in the goal of helping vulnerable elderly and handicapped persons remain in the community. This provision does not affect the States' authority to impose limitations on amount, duration and scope of services provided to other Title XIX eligibles not included in the community care plan.

The Committee recognizes that in order to provide a mix of appropriate and cost effective services tailored to the needs of individual recipients, it would be unwise to set a limit on the specific amount and type of services available to each client. But to insure fiscal responsibility, States may establish an annual per capita ceiling on the cost of the total amount of services each client may receive. This limit need not be less than the amount required to maintain the applicant in an institution for a 12-month period. Since service costs for a client are often higher during the initial period of care (for example, when a patient is discharged from a hospital after an acute illness) than they are when the client's condition is more stable, the State will be allowed to average the per-person cost of care over a 12-month period to arrive at the total. The experience of the New York State long-term home care program has found this an effective fiscal device.

Since the cost and availability of community-based care are of concern to the Committee and to the States, this section requires States

to establish minimum and maximum reimbursement rates. The Committee intends that the establishment of minimum reimbursement levels will assure adequate payment to service providers so as to encourage them to participate in the program. Maximum rates assure that costs can be controlled while providers deliver reasonably priced and adequate care. The Committee wishes to encourage innovation by States to determine these reimbursement levels and therefore allows States to examine a wide variety of methods, such as capitation, fee for service, or others, and to make use of prospective or retrospective reimbursement methods in developing a plan for payments. The Committee anticipates that this flexibility will enable States to achieve optimal cost efficiency and simplification of program administration.

The Committee requires States to submit data to the Secretary under a uniform data collection plan. This is needed to obtain accurate information on the kinds of services States have made available under this program, and to assess the relationship between the provision of community-based services and the utilization of hospitals and long-term care facilities by program recipients, and to compare their costs. The General Accounting Office, in its report "Entering a Nursing Home: Costly Implications for Medicaid and the Elderly", strongly recommended this measure. In this connection, the Committee would recommend that the Secretary review data collection systems currently being used in long term care programs in different States ("channeling" contracts now being administered in HHS utilize a consistent system, for example) to determine the possibility for this program to use a data collection system already developed.

State reports to the Secretary must include all services provided under the plan for community care, as well as a detailed compilation of total expenditures, under all federal programs, for institutional and non-institutional, direct and indirect, services in support of long term care.

The development and implementation of a State community care plan is a time-consuming and complex process, often requiring the coordination of several agencies, and sometimes State legislative action. Many areas of the country do not have community-based services readily available, or sufficiently developed to take care of the needs of large numbers of people. Therefore, the section allows States to apply to the Secretary for a one time waiver of the State-wideness provision, for a three-year period. This will enable a State to initiate an assessment and delivery system in one part of that State, and there test out methods for provision of service, for reimbursement, etc., which over a three-year period can be applied to the State as a whole.

It is the intent of this section that no Medicaid eligible person, in a State which adopts this option, shall enter a SNF or an ICF, or ICF-MR, who has not had an assessment which indicated such placement was appropriate. The Secretary is expected to define those urgent circumstances under which this requirement may be waived since elderly and handicapped persons often need immediate or emergency placement. This provision, for mandatory assessments before a Medicaid eligible person may be placed in a long-term care facility, takes effect in all States on or after October 1, 1982.

All other provisions of this section are voluntary, and become effective October 1, 1981. The Committee intends for States which are ready and willing to prepare a plan for assessment and provision of community-based services be able to do so at the earliest possible time.

The Committee bill provides that State expenditures for both institutional services and non-institutional services, included under this section, shall not exceed the amount which a State would otherwise spend on institutional and noninstitutional long-term care services ordinarily covered under its Medicaid plan.

The Secretary may enter into an agreement with a State regarding the amount of expenditures that will be recognized, for purposes of payment to the State for long-term care services under its State plan.

In reaching an agreement on recognized levels of expenditures for long-term care services, a State and the Secretary must demonstrate that their agreement includes a determination of the institutional and noninstitutional long-term care needs of the State's Medicaid population, and the cost of promptly providing adequate levels of services to program beneficiaries. The agreement must not establish arbitrary expenditure ceilings that prevent access by program beneficiaries to essential long-term care services.

The Committee emphasizes that assurances regarding the level of expenditures for long term care must reflect and include the total expenditures under all Federal programs for institutional and noninstitutional long term care services.

Section 6330 - Encouraging HMO Participation in State Medicaid Plans

The section provides that any risk-based payment arrangement between a State Medicaid Agency and qualified HMO would have to be undertaken pursuant to a contract meeting certain specified assurances. Further, within three years of entering into such a contract, an HMO would be required to have a membership of which at least 25 percent of the enrollees were not medicare or medicaid beneficiaries; the Secretary would be authorized to waive this requirement for public entities. Finally, the section authorizes States to negotiate enrollment periods of up to 6 months for medicaid eligibles choosing to enroll in HMOs, with the assurance that Federal matching funds will be available regardless of any changes in their eligibility during that period.

Under current medicaid law, States may enter into prepaid capitation or other risk-basis payment arrangements only with entities that the Secretary has determined meet the HMO standards under Title XIII of the Public Health Service Act. In addition, within 3 years of entering into a contract with the State, an HMO must have an enrollment composed of no more than one half medicare or medicaid beneficiaries. These requirements do not apply to certain entities identified in regulation as Prepaid Health Plans (PHPs), principally community health centers and rural primary health care entities that were receiving grant funds in fiscal year 1976.

The Committee is concerned that current medicaid law does not provide sufficient encouragement for HMO participation in the medicaid program. As of June, 1980, only 17 State Medicaid Agencies had entered into risk-based payment arrangements with HMOs (or PHPs); these contracts covered some 270,000 medicaid enrollees, or just a little over *one percent* of all medicaid eligibles. In view of the demonstrated cost-effectiveness of HMOs, the Committee believes that more medicaid eligibles should have the choice of receiving care from a qualified HMO. This will require greater State Agency activity as well as greater interest and initiative on the part of HMOs.

The Committee bill clarifies current law to require that any risk-basis payment arrangement with a State Medicaid agency be undertaken under contract. The Contract must provide that the State or the Secretary has the right to audit and inspect the records pertinent to the HMO's financial solvency, services provided, or payments received under the contract. The contract must also prohibit the HMO from discrimination among medicaid eligibles on the basis of health status or need for health care in its enrollment policies or procedures. The purpose of this prohibition, which is intended to benefit both the State and eligible recipients, is to avoid "skimming" of low-risk medicaid eligibles by contracting HMOs. Finally, the contract must provide that the HMO notify each medicaid eligible, at the time of enrollment, of that individual's rights to disenroll, without cause, upon one month notice. This provision is intended to assure that medicaid eligibles have the option to seek care promptly from competing providers should they become dissatisfied with the service or performance of the HMO in which they are enrolled.

The Committee bill alters the current limitation with respect to medicare and medicaid enrollment in HMOs participating in medicaid. With the exception of certain statutorily-identified entities (PHPs), HMOs participating in medicaid currently are prohibited from having an enrollment that consists of half or more medicare or medicaid eligibles. This requirement, which applies 3 years after the HMO first enters into a medicaid contract, was first established in 1976 (Public Law 94-460) in response to Congressional concerns about the adverse quality implications of "poor people's HMOs," especially the tendency to underserve enrollees. These concerns, which derived mainly from the experience under the California Prepaid Health Plan Program in the early 1970's, remain applicable today, notwithstanding improvements in the art of quality assurance in HMOs since then. At the same time, the Committee recognizes that, in some areas, the 50 percent limitation on medicare and medicaid enrollment may be unrealistic,

even with a 3-year compliance period. Accordingly, the Committee bill would raise the ceiling on combined medicare and medicaid enrollment to 75 percent. (It should be noted that, under section 1 of this bill, total medicare enrollment in an HMO would be limited to 50 percent.) The requirements in current law that the HMO demonstrate continuous efforts and progress toward compliance with the 75 percent ceiling during each of the 3 years would remain unchanged. This will assure that within 3 years of the initiation of a contract between an HMO and a State Medicaid Agency, at least one out of every four enrollees will be a private enrollee.

The Committee bill provides the opportunity for a waiver of this new 75 percent limitation on medicare and medicaid enrollees in the case of public entities. The Committee understands that this ceiling may preclude some county and municipal hospitals and health departments from establishing a viable HMO, because the patient mix in their service areas consists largely, if not exclusively, of public program beneficiaries and persons with no other source of payment. Under these circumstances, it may well be unrealistic to expect a public hospital or clinic-based HMO to achieve 25 percent private enrollment within 3 years of entering into a medicaid contract. The Committee bill therefore authorizes the Secretary to modify or waive the limitation for public HMOs, for such period as he or she deems appropriate, if special circumstances (such as the high proportion of medicare and medicaid beneficiaries in the HMO's service area) warrant and if the HMO is making reasonable efforts to enroll non-medicare or nonmedicaid members. The Committee intends that the Secretary periodically review any such modifications or waivers to assure that the public HMOs are in fact continuing to make reasonable efforts to enroll members of private or public employee groups in their service areas.

The Committee bill authorizes, but does not require States to negotiate an enrollment period of up to 6 months, for medicaid eligibles who elect to enroll in an HMO, with the assurance that Federal matching funds will be

available for the HMO coverage for the individual during that period. Under current law, if a medicaid beneficiary enrolls in an HMO in one month and shortly thereafter loses his or her eligibility for benefits due to excess income, the HMO must be denied payment for services provided after the individual becomes ineligible. From the HMO's standpoint, this makes the medicaid market unstable and therefore unattractive. The Committee bill would therefore allow States, where they felt it appropriate to encourage HMOs to participate in their medicaid programs, to guarantee the HMOs payment for each medicaid enrollee for a minimum period of up to 6 months after initial enrollment, and to receive the appropriate Federal matching payments. This guarantee of a six-month enrollment would apply only to individuals who involuntarily lost eligibility; medicaid beneficiaries who voluntarily disenrolled due to dissatisfaction or for other reasons could not be covered under such an arrangement.

The Committee bill does not address this issue of payment methodology.

Section 6331 - Eliminating Federal Matching for
Excessive Preoperative Stays and Unnecessary Tests

Under current law, many States have not taken steps to eliminate payment under their Medicaid program for excessive preoperative stays or for hospital tests which have not been specifically ordered by the physician. If they pay for this care, then the Federal government pays its share of these costs. The proposal would reduce Federal expenditures and encourage improved State management practices by eliminating Federal matching for preoperative stays in excess of one day before elective surgery or for inpatient tests which have not been specifically ordered by the physician except in emergency situation.

The Committee intends to enable States and the Secretary to withhold payments in the case of a patient admitted to a hospital for an elective surgical procedure for care and services furnished to the patient during that stay in the hospital more than 1 day before the date of the procedure. The Committee also intends States and the Secretary to withhold payments for inpatient hospital tests (other than emergency care) not specifically ordered by the patient's physician or other responsible practitioner. The Committee, however, intends this procedure to not apply in cases where tests are required for diagnosis of the patient's case or in situations of emergency where prompt diagnosis and treatment are necessary. It is the intention of the Committee to have the Secretary define by regulation according to professionally recognized criteria what constitutes elective surgery. In addition, the Committee believes this regulation should also specify conditions and elective procedures which require a preoperative stay of more than one day in order to protect the patient's health and wellbeing. Such elective procedures would be exempt from the one day preoperative stay limitation.

The Committee recognizes that many patients are admitted to hospitals for an unnecessarily long time before elective surgery. This drives up hospital costs without providing improved medical care for the patient. Thus, such stays are expensive and an unnecessary expenditure for the Medicaid program and not necessarily beneficial to the patient.

The Committee has also learned that many hospitals routinely perform numerous tests on patients that are not specifically needed to diagnose the patient's condition or determine the appropriate course of treatment. In many cases, these tests are routinely administered and are not specifically ordered for the particular patient by his physician. The performance of these tests also drives up costs unnecessarily.

The Committee intends to give States and the Secretary the authority to address these problems by withholding payment under Medicaid for preoperative stays in excess of one day for elective surgery and for tests not specifically ordered by the physician. The Committee believes these restrictions will result in cost savings to the Medicaid program without reducing the quality of care to program beneficiaries. The State of Maryland has already implemented the preoperative stay limit for its Medicaid program. The Committee intends other States to implement similar restrictions on hospital care for elective procedures.

However, the Committee does not intend the restriction of preoperative days to apply in cases where the patient is admitted for immediate elective surgery and surgery is then postponed due to complications in the patient's condition, such as presence of an infection that required treatment before surgery could be safely undertaken. In addition, the Committee recognizes that the need for surgery, even of an elective nature, is in some cases determined after a patient has been admitted to a hospital and received a diagnostic work-up. In such cases of unscheduled surgery, the Committee recognizes that the one day preoperative stay limitation may be inappropriate and Medicaid matching should not be withheld.

Moreover, the Committee's intention with regard to withholding payments for inpatient hospital tests not specifically ordered by the patient's physician or other responsible practitioner is to eliminate tests routinely administered in the hospital that are not required as part of the patient's course of treatment. The Committee does not intend this provision to in any way restrict payment for tests and other diagnostic procedures the patient's physician deems necessary for the appropriate treatment of his or her patient. The Committee also believes such payment restrictions are inappropriate with regard to diagnostic testing in an emergency situation where timely identification of the cause and extent of the patient's illness is essential.

The Committee believes these actions will help limit preoperative stays for elective surgery and unnecessary diagnostic testing and thus help to reduce hospital costs under Medicaid. However, the Committee does not intend this provision to be used to reduce needed hospitalization for elective surgery or tests ordered by the patient's physician to diagnose or direct a course of treatment for the patient's condition.

Current law requires that States control the utilization of hospital, SNF, and ICF services through physician certification. A physician must certify need for in-patient services at the time a medicaid-eligible individual is admitted to such a facility, and recertify this need at least every 60 days during the patient's stay.

The Committee agrees that it is necessary for a physician to perform the initial certification, to insure the most accurate diagnosis and plan of care. The Committee finds, however, that physician assistants and nurse practitioners, under the supervision of physicians, are well qualified to perform the recertification of the patient's need for continued in-patient care. Such professionals have the proper basic skills needed to perform the numerous tasks involved in recertification and can be trained in any additional skills which are required.

The Committee feels that using physician assistants and nurse practitioners may be an effective way of reducing costs while not sacrificing quality of service.

Sec. 6332 would allow physician assistants and nurse practitioners within the scope of their practice under state law to perform the recertification function at least 60 days after the patient's admission, and at least every 60 days thereafter during the patient's stay.

Current law makes no distinction about the need for recertification every sixty days of persons in different kinds of in-patient facilities.

The Committee finds that ICF-MRs serve patients with mental and developmental disabilities. Such persons progress at a slow rate, and therefore do not need frequent recertification. The Committee finds that recertification could be undertaken once every year, at a cost saving and with no lessening of standards of care.

The Committee emphasizes that this provision in no way indicates that one year is the appropriate length of stay for a person in an ICF-MR. That judgment is left to the professional staff responsible for patient plans of care and rehabilitation.

As in the case of other inpatient facilities referred to in this section, the Committee finds that physician assistants and nurse practitioners may be allowed to perform recertification once every year for patients in an ICF-MR, within the requirements of state law.

Section 6333 - Limitation on Requirement for Collection
of Third Party Payments

Under the current law, States are required to recover from other third party payors any monies that are due for services provided to a Medicaid recipient who has this private insurance coverage.

The Committee recognizes that in some instances the amount to be recovered in pursuing a claim for reimbursement from a potentially liable third party may exceed the cost of the potential recovery. The State plan requirements should accommodate this possibility and allow the Medicaid program to exercise sound business discretion in the pursuit of third party claims. This provision of the bill provides that the requirement to recover the third party liability would apply only where the amount of recovery can reasonably be expected to exceed the cost of pursuing the recovery. This change does not diminish the requirement that potential liability be ascertained and pursued where the expected recovery can reasonably be expected to exceed the costs of such recovery.

Section 6334 - Repeal of Obsolete Authority

Prior to the enactment of title XIX, many of the other cash payment programs under the Social Security Act included payments for medical care. Under current law, these provisions are no longer utilized; medical assistance payments are made under title XIX. This provision repeals those various authorities throughout the Act which have now become obsolete.

Section 633E. Study of Federal Medical Assistance Formula

The bill requires the Comptroller General, in consultation with the Advisory Committee on Intergovernmental Relations, to study the current matching formula and recommend revisions to the Congress by March 31, 1982.

Under current law, the Federal share of a particular State's payments for medical services to Medicaid beneficiaries is calculated using a statutory formula, called the "Federal Medical Assistance Percentage" or "FMAP". The FMAP formula provides a higher matching rate for Medicaid benefit expenditures for States with low per capita incomes. The Federal share of Medicaid expenditures in a given State is determined as follows:

$$\text{Federal share} = (.55) \left(\frac{\text{national per capita income}}{\text{State per capita income}} \right)^2$$

By statute, no State can be matched higher than 83 percent or lower than 50 percent.

The FMAP formula was designed to provide a higher percentage of Federal matching to States with low per capita incomes and a lower percentage of Federal matching to States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share would be 55 percent. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50 percent. If a State's per capita income is lower than the national average, the Federal share is increased up to a statutory maximum of 83 percent. However, no State currently receives more than 77.55 percent.

The formula provides for squaring both the State and national average per capita incomes. This procedure magnifies any differences between the State's income and the national average. Consequently, Federal matching to

low income States is increased and Federal matching to higher income States is decreased.

The FMAP formula has been criticized on numerous grounds and several bills to change the FMAP formula have been introduced in the Congress in recent years. The FMAP formula has not been changed since enactment of Medicaid in 1965. The Committee is concerned that the formula may no longer provide for the equitable distribution of Federal funds to the States under the Medicaid program.

The Committee recognizes the importance of the matching formula in the distribution of Federal funds to the States to support the Medicaid program. Minor changes in the formula can result in shifts of millions of dollars in Federal Medicaid funds from one State to another. Therefore, the Committee believes that permanent changes in the Medicaid FMAP formula should not be undertaken without extensive study of the implications of alternative approaches and careful review and deliberation by the Committee.

In order to prepare for future consideration of changes in the FMAP formula, the Committee has requested the Comptroller General to undertake a study of the matching formula in consultation with the Advisory Committee on Intergovernmental Relations. The Committee intends this study to examine the existing formula and make recommendations on:

- retaining the squaring factor which has served to provide proportionately more Federal funding for welfare programs to the poorest States
- adjusting State per capita *income* to account for:
 - cost of living allowance among States
 - non-taxable transfer payments, such as welfare and social security benefits, which are currently included in the definition of per capita income

- Federal taxes paid by State residents
- possible taxable resources such as land, minerals, and tourism potential
- unemployment rate differences among States
- taking into account measures of relative cost to a State of a Medicaid program, such as:
 - relative medical care prices in each State, or
 - relative size of low-income population in each State
- providing a mechanism in the formula to enable the formula to be responsive to the impact of changing economic conditions on State tax receipts and fiscal resources

The Committee intends the study to address the fairness and appropriateness of the existing formula and to examine whether and how the formula might be revised to take into account the relative economic positions of the different States, the relative amount of taxes raised per capita in the different States and other factors related to the equitable distribution of Federal funds for Medicaid. The Committee intends the Comptroller General's report including recommendations for revisions to the existing formula to be provided to the Congress by March 31, 1982.

Elimination of Occupancy Test for Hospital Long-Term
Care in Nonpublic Hospitals (Section 6336)

Present law, as amended by Public Law 96-499, provides that, where a beneficiary who no longer requires acute hospital services must remain in the hospital because no long-term care bed is available in the area, the hospital will be reimbursed at a daily rate equal to the adjusted average Medicaid skilled nursing facility (SNF) rate in the State for persons needing SNF services, and for purposes of Medicaid, at the intermediate care facility (ICF) rate for patients needing ICF services. The reduced level of reimbursement does not apply where a hospital's annual occupancy rate is equal to or greater than 80 percent.

The bill generally eliminates the special treatment of hospitals meeting the occupancy test. Thus, a hospital's occupancy rate would no longer be a factor in determining whether reimbursement is to be made at the reduced rate.

The bill makes an exception with respect to public hospitals; for public hospitals, which serve as hospitals of last resort for the poor and many of which are financially distressed, the 80 percent occupancy test would be retained. In addition, the bill specifies that the reduction in reimbursement would not be imposed for Medicare reimbursement purposes with respect to any hospital if the Secretary determines that there is no excess of hospital beds in the area in which the hospital is located. This exception would not apply to Medicaid, although a State at its option could choose to apply it.

Elimination of the occupancy test for most hospitals reflects the Committee's view that, in a period when hospital costs are continuing to rise dramatically and numerous long-term care patients inappropriately remain

in acute care hospital beds, it is appropriate to provide additional incentives for the establishment of needed long-term care beds, and especially for the conversion of acute care beds to long-term care beds.

The Committee recognizes that in certain instances repeal of the 80 percent occupancy rate exemption will cause undue hardship. In order to alleviate such hardship, the Committee has retained the occupancy test for public hospitals, which generally serve many Medicaid patients and persons without third party payment coverage.

Civil Money Penalties (Section 6337)

Under present law, the Secretary of HHS has no independent authority to impose monetary penalties for fraudulent claims under the Medicare or Medicaid programs. Currently, the Secretary's authority is limited to barring practitioners or providers from participation or referring cases of criminal fraud to the Department of Justice for prosecution. The Secretary is authorized to bar from participation practitioners or providers who submit false or excessive claims and is required to bar from participation those individuals who have been convicted of a criminal offense with respect to Medicare or Medicaid.

Under both Medicare and Medicaid, acts of knowing and willful fraud as well as bribes and kickbacks are felonies punishable by a maximum fine of \$25,000 or 5-years imprisonment. The Secretary is currently authorized to impose a civil money penalty only in cases where such a penalty has been recommended by a Professional Standards Review Organization.

The bill authorizes the Secretary of Health and Human Services to impose a civil money penalty of not more than \$2,000 for each item or service under a fraudulent claim for reimbursement under the Medicare or Medicaid programs. The Secretary would also be authorized to impose, in addition to the penalty, an assessment of not more than twice the amount claimed for each item or service and to bar from participation in Medicare, and the Federal portion of Medicaid, any person determined to have filed a fraudulent claim.

The Secretary could impose a penalty in cases where the Secretary determines that the person knew or had reason to know that the item or service was not provided as claimed; where such person had been barred from

participation under another provision of the Social Security Act; or where the claim was submitted in violation of an agreement between the person and the Federal or State government.

Proceedings to impose a civil money penalty would be initiated only as authorized by the Department of Justice pursuant to procedures agreed upon by both the Departments of Justice and HHS. Before the Secretary could impose a penalty, the Secretary would be required to give written notice and an opportunity for a determination on the record after a hearing at which the person would be entitled to be represented by counsel, to present witnesses and to cross-examine the witnesses against him.

Whenever a civil money penalty has been assessed the Secretary may bar the person from participation in titles XVIII and XIX. If a hearing regarding the suspension occurs, the record of the hearing regarding the imposition of the civil money penalty would be conclusive as to the issues considered therein. In a case in which the Secretary has acted to bar a person from participation, the Secretary would be required to provide notice of such action to the appropriate State Medicaid agency.

In determining the amount of the penalty assessed, the Secretary would be required to take into account the nature of the claims and the circumstances under which they were presented as well as the degree of culpability, history of prior offenses, and financial condition of the person presenting the claim.

Any person against whom a penalty was assessed would be entitled to Federal judicial review of a final determination of the Secretary by requesting such a review within 60 days after he was notified of the Secretary's order. In the proceeding before the court, the finding of the Secretary with respect to questions of fact, if supported by substantial evidence on the record, would be conclusive.

In any case in which the penalties and assessments imposed by the Secretary with respect to services rendered during a year exceeded \$25,000 the person would be entitled to a trial de novo in Federal court.

Amounts recovered as a result of a Medicaid claim would be returned to the State in proportion to its medicaid matching share; amounts representing a medicare claim would be returned to the medicare trust funds, and the remainder would be deposited in the general fund of the U.S. Treasury.

The civil money penalty provided for in this bill is intended to provide an alternative to criminal proceedings so as to increase the effectiveness of enforcement in the medicare and medicaid programs. There are presently numerous cases identified by the Inspector General of HHS which are clear cases of fraud but which are not prosecuted by the Justice Department because they are excessively time consuming or do not warrant imprisonment. It is hoped that this mechanism will provide the Secretary with additional flexibility in pursuing cases of fraud under the programs.

While the Committee believes that civil money penalty proceedings are necessary for the effective prevention of abuses in the medicare and medicaid programs, the Committee is concerned that such proceedings not be initiated lightly. It is anticipated that the Secretary will administer the civil penalty judiciously, using it only where the severity of the violation so warrants. Further, the Committee expects that cases initiated under this provision will be subject to full investigation and substantiation and that alleged violators will receive procedural rights consistent with administrative due process.

The provision would become effective upon enactment.

Section 6338 - Limitation of Medicare and Medicaid
Payments for Certain Drug

The Committee's proposal would discontinue Medicare Part B and Medicaid reimbursement for those prescription drugs which were approved prior to the 1962 amendments to the Federal Food Drug and Cosmetic Act (FFDCA) and subsequently are determined to be less than effective in use.

Prior to the 1962 amendments drugs were tested and approved for their safety only. The 1962 amendments established the current requirement that drugs be proven effective and required that all drugs which were approved for their safety at that time be reviewed for their efficacy. The review has been performed in a two step process and is still being conducted.

The first step of the review is conducted by expert scientific advisory committees, which report to the Commissioner of the Food and Drug Administration; and the second step is conducted by the Commissioner. If, after all review is completed, the Secretary of HHS determines that a drug is less than effective for all conditions of use; the Secretary proposes an order to withdraw approval of the drug and issues a notice of an opportunity for a hearing under section 505 (e) of the FFDCA. When the Secretary has made such a determination about a drug, the Committee believes that the drug's use should not be reimbursed unless there is a compelling medical justification for its use. If the drug is subsequently proven to be effective, then reimbursement would be allowed. Termination

of reimbursement would also apply to all identical, related or similar drug products which are not medically necessary.

Section 6339 - Withholding of Payments for Certain
Medicaid Providers

The Committee recognizes that certain institutional and individual Medicaid providers subject to offsets for the collection of overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid agency and the Secretary unable to recover the amounts due. This provision establishes a mechanism for determining the amount of Medicaid overpayment and withholding payments to Medicare institutional providers and individual Medicare providers who accept payment on the basis of assignment. It is the intention of the Committee to condition the noted participation in Medicare on the stated interaction with Medicaid just as the law now provides for withholding Medicaid payments from providers subject to an overpayment claim under Medicare. The Committee recognizes that providers who refuse assignment are not subject to the provision. This is true because there is no mechanism to effect an on offset in the care when the patient makes payment directly to the provider.

Technical Corrections for Errors Made by the Medicare
and Medicaid Amendments of 1980 (Section 6340)

Several technical drafting errors were included in present law by the Medicare and Medicaid Amendments of 1980 (title IX of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980). The most significant of these errors is the deletion from prior law of a provision limiting Medicare Part B reimbursement to the lower of the provider's customary charge or the reasonable cost of the covered service.

Reduction and Repeal of Professional Standards Review
Organizations (PSRO's)(Sections 6341-6345)

Under present law, PSRO's are charged with the comprehensive and ongoing review of the services provided under medicare, medicaid and the maternal and child health programs. PSRO's determine, for purposes of reimbursement under these programs, whether services are: (1) medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

PSRO's are formed by organizations representing substantial numbers of practicing physicians in 194 geographic areas nationwide. There are currently 47 fully designated and 140 conditionally designated PSRO's in operation.

The major focus of the PSRO program has been on review of inpatient hospital services. While PSRO's are also charged with review responsibilities in other health care settings, budget restrictions have limited review outside the hospital setting.

Under the bill, the Secretary of Health and Human Services would be required to develop and apply specific criteria for the evaluation of the performance of PSRO's. On the basis of such evaluations, the Secretary would be permitted to terminate no more than one-half of all PSRO's prior to October 1, 1982. States would have the option of contracting with PSRO's for medicaid review at a 75 percent Federal matching rate.

Under sections 6341-6345 of the bill, the Secretary of HHS would be required, by September 30, 1981, to establish specific criteria for evaluation of the performance of PSRO's. Those criteria would take into account the PSRO's effectiveness in monitoring the quality of care, managing

its activities efficiently, reducing unnecessary utilization and such other criteria as the Secretary may determine appropriate. Based on the criteria so established, the Secretary would be required to assess the performance of PSRO's and determine their relative effectiveness.

The Secretary would then be authorized to terminate the least effective PSRO's, but in no case would the Secretary be permitted to take action which would result in the termination or nonrenewal of more than one-half of all PSRO's prior to October 1, 1982.

Further, by October 1, 1982, the Secretary would be required to redesignate PSRO areas to provide generally for a single PSRO area per State. In cases of very large States (such as New York and California) where a single PSRO could not carry out review efficiently, up to five areas could be designated. The Committee believes that in this time of reduced funding and elimination of less effective PSRO's, the maximum productive review can be achieved by designating fewer areas and expanding the review areas of the effective PSRO's.

Under the provisions of the bill, the Secretary would be required to establish criteria for evaluating the relative effectiveness of PSRO's. It is the intent of the Committee that such criteria would be established in consultation with individuals and organizations with experience in conducting peer review. The criteria would then be applied in such a way as to terminate those PSRO's which have been the least effective in controlling costs or reviewing the quality of care.

A number of PSRO's have established effective mechanisms for the collection and utilization of data on hospitals within the PSRO area. This information has proved useful in assisting PSRO's, hospitals, and the medical community to determine patterns of utilization and patient care and

to reduce unnecessary utilization and improve the quality of care.

It is anticipated that such effective collection and use of data will be included among the criteria used to evaluate PSRO performance.

Under the bill, a PSRO would receive 90 days notice of termination. The present law right of a PSRO to a hearing in the case of termination of an agreement would be repealed except with respect to a PSRO with an annual agreement in existence on the date of enactment. Termination of an agreement by the Secretary under this provision would not be subject to judicial review.

Under current law, the Secretary is required to make payments to a PSRO for expenses incurred in the performance of its duties from the medicare trust funds and from general revenue appropriations in proportion to the costs attributable to each of the programs reviewed. The costs of administration and review with respect to the medicare program are paid from the hospital insurance trust fund.

It is the intent of the Committee that, with respect to those PSRO's which have not been terminated and which continue to perform the activities provided for in their agreement with the Secretary, funds will continue to be expended from the medicare trust fund for purposes of PSRO administration and review of medicare services, at no less than the PSRO's allocation based upon the funding level set forth in the fiscal year 1981 continuing resolution.

Under the bill, recent limitations placed on the scope of review by PSRO's would be removed to provide more flexibility for the remaining PSRO's. Authority would be returned to the Secretary to permit a PSRO to review ancillary, ambulatory, or long-term care services. In addition, PSRO's would be authorized, rather than required, to delegate review activities to hospitals, skilled nursing facilities and intermediate care facilities.

With respect to medicaid review, section 6343 of the bill would provide States with the option of contracting with PSRO's where they believed their review was effective, or carrying out their own utilization review activities. A State could elect to use some but not all of the PSRO's in the State (and carry out its own utilization review activities in the areas outside the areas of the PSRO's selected). This option is designed to provide States with maximum flexibility to secure the most effective review possible.

Federal sharing in the cost to the State of contracting for PSRO review would be at the normal administrative matching rate for costs of skilled medical personnel, i.e., at 75 percent. Currently, the Secretary contracts with a PSRO to do both medicare and medicaid review with the Federal government financing 100 percent of the cost. Under the bill, a PSRO would be required to enter into a contract with the State at the State's option for medicaid review under terms and conditions similar to those contained in an agreement between a PSRO and the Federal government. Such review could not be inconsistent with the purposes of medicare review. The Committee anticipates that those PSRO's which have been effective in reducing hospital costs within the State will continue to be funded by the State for purposes of medicaid review.

The Secretary of HHS would be required to report to the Congress by September 30, 1982, on the termination of PSRO's occurring to that date and on the performance of the remaining PSRO's.

Section 6344 of the bill makes an additional conforming change made necessary by the expected elimination of some PSRO's. Under current law, as provided for in Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, where a beneficiary no longer requires acute hospital services but must remain in the hospital because no long term care bed is available

in the community, medicare reimbursement is reduced to the long-term care rate, with certain exceptions. Under this provision, the determination as to whether the patient requires acute or long-term care was to be made by a PSRO. In the absence of PSRO review, the provision would become inoperative.

Under the Committee bill, the Secretary of HHS or such agent as the Secretary may designate, would be authorized in the absence of a PSRO, to carry out such review.

The section would become effective upon enactment.

Increase In, and Indexing of, Part B Deductible
(Section 6347)

Under present law, medicare part B beneficiaries are subject to a \$60 annual deductible and are thus responsible for the first \$60 of the cost of covered services (with certain exceptions).

The bill amends present law to increase the annual part B deductible from \$60 to \$70, and, beginning in 1983, to index the deductible so that it increases each year by the same percentage as the annual cost of living increase in monthly social security cash benefits.

Each year, beginning in 1982, the Secretary will announce the amount of the part B deductible for the next calendar year. The deductible will be rounded to the nearest multiple of \$1. The Secretary's announcement will be made at the time the annual cost-of-living increase in monthly social security benefits is announced. The deductible increase announced will reflect the percentage increase in social security benefits in that year and will become effective on January 1 of the following year.

Despite the upward spiral of health care costs, no change has been made in the deductible since 1973. The Committee's decision to increase and subsequently index the part B deductible reflects its desire to update the deductible and to restrain increases in the cost of the program without eliminating benefits or imposing unreasonable burdens on beneficiaries. Indexing the part B deductible makes its treatment consistent with the annual adjustment of the part A deductible and coinsurance, and the annual increase in the part B premium provided for under present law.

The increase in the deductible to \$70 will become effective for expenses incurred during calendar year 1982. The indexing of the deductible will be effective for expenses incurred during calendar year 1983 and later years.

Incentive Reimbursement Rate for Renal Dialysis
Services (Section 6348)

Amendments to the Social Security Act made in 1978, Public Law 95-292, were designed to accomplish several objectives including, among others, providing incentives for the use of lower cost, medically appropriate self dialysis (particularly home dialysis), as an alternative to higher cost institutional dialysis. With respect to the objective of increasing the use of lower cost medically appropriate home dialysis, the Committee notes that, since enactment of the amendments of 1978, there has been a modest increase in the numbers of end stage renal disease (ESRD) patients self dialyzing at home. Considering the rapid decline in home dialysis utilization during the initial 5 years of the program, this recent reversal of that decline is encouraging.

However, given the continuing escalation in both the population of ESRD patients and program costs and given current estimates that a substantially greater number of renal patients could be dialyzed in the home setting, the Committee believes that there is a need for increased efforts to stimulate greater growth in the percentage of patients dialyzing in the home. While the Committee recognizes that not all patients are medically appropriate candidates for home dialysis and some local variances in the proportion of home patients is understandable, there is concern that in most localities only a very small percentage of ESRD patients are dialyzing at home.

The bill requires the Secretary of Health and Human Services to prescribe in regulations a method (or methods) for determining the amounts of payments to be made for renal dialysis services, incorporating in a single reimbursement rate structure, reimbursement for dialysis treatments in a facility and dialysis treatments in the home setting. The method

promulgated by the Secretary would provide for a prospectively set rate (or rates) for each mode of care, and would be established on the basis of a single composite weighted formula taking into account the proportions of an institution's patients dialyzing in the facility and those dialyzing at home. If the Secretary, after detailed analysis determines that an alternative rate setting method would provide greater incentives for increased use of lower cost home dialysis than would a single composite rate, such an alternative rate setting method may be promulgated. The Committee intends that the new method of payment for dialysis services may be used in lieu of present law provisions concerning target reimbursement for home dialysis services.

Because of its concern over the potential impact of the single facility rate, the Committee's bill would require the Secretary to examine an alternative method which would incorporate reimbursement for facility dialysis and home dialysis in one rate; that is, a single composite rate. The Committee expects the Secretary to consider the composite rate before any regulations implementing any other changes in the renal dialysis reimbursement rate are promulgated.

The Committee believes the composite rate approach will encourage all facilities to pursue the goal of increasing self care, particularly home dialysis. The determination as to where patients are treated, that is, facility, facility self care, or home and the type of treatment provided, such as, hemodialysis, standard peritoneal, continuous, ambulatory peritoneal dialysis remains the prerogative of the attending physician. No specific home dialysis goals are mandated but the reimbursement incentive should encourage the selection of the least costly medically appropriate form of treatment for each patient.

In addition, in an effort to eliminate any remaining disincentives for

home dialysis, the Secretary would be expected to consider some liberalization of reimbursement for home training expenses incurred by the patient and family member who will assist them with home dialysis.

This provision would apply to services furnished on or after October 1, 1981.

Limits on Reimbursement to Home Health Agencies
(Section 6349)

Present law authorizes the Secretary of HHS, in determining the reasonable costs of services furnished to medicare patients, to exclude costs estimated to be unnecessary in the efficient delivery of needed health services. In implementing this authority with respect to home health services, the Secretary has established a schedule of reimbursement limits for home health agencies which is updated periodically. The limits are expressed in terms of costs per visit, and although they are established by type of service (e.g., skilled nursing home health aide), they are applied to each home health agency as a single aggregate limit, based on the agency's number of visits for each type of service. (Currently, the limits under this methodology are set at the 80th percentile.

The bill would reduce from the 80th to the 75th percentile the medicare reimbursement limits currently applied to home health agency costs, thus establishing a more stringent criterion for determining whether costs are excessive. In view of the need for cost constraint, the Committee believes these tighter limits are an appropriate means of encouraging efficient operation of home health agencies.

The Committee does not intend to preclude the Secretary from modifying in the future the methodology for establishing home health reimbursement limits and recognizes that, under a modified approach, it may no longer be appropriate to set the limits at the 75th percentile. For example, a limit determined in relation to the mean of per visit costs may in the future be found to be appropriate. Accordingly, the bill specifies that the limit is to be either at the 75th percentile or such lower percentile or such comparable or lower limit as the Secretary may determine. Whatever methodology is used, however, the intention is that

the limits be set at a level no less stringent than what is represented by the 75th percentile under the current methodology.

Under a classification system used for determining and applying the current home health reimbursement limits, there are separate limits for provider-based (primarily hospital-based) home health agencies and for free-standing home health agencies. The limits for hospital-based agencies are significantly higher than those for free-standing agencies. Freestanding agencies have questioned the fairness of the separate category for hospital-based agencies, claiming that the separate limits discriminate against them and put them at a competitive disadvantage. Some have also suggested that subjecting provider-based home health agencies to the lower limits applicable to freestanding agencies would offer an opportunity for reduction in medicare program costs.

On the other hand, the justification given for the current use of separate limits is that they are necessary to avoid unjust reimbursement penalties resulting from medicare's hospital cost allocation requirements. These requirements force hospital-based home health agencies to include in their cost reports a share of the costs from the hospital's overhead accounts that is not directly commensurate with the costs incurred by freestanding agencies.

The Committee is concerned about the apparent anomaly of separate limits for hospital-based and freestanding home health agencies, despite the fact that both render similar services. Accordingly, the Committee expects the Secretary to make a comprehensive reassessment of the continued need for separate limits, of the prospects for revising medicare hospital cost-allocation procedures, and of other possible changes in response to concerns arising from the existence of separate limits. The Committee

requests that the Secretary report to the Congress no later than January 1, 1982, on the findings of this study, and include in the report any planned or proposed changes relating to the issue of separate limits and the timetable for their implementation.

Section 424 of the bill is effective with respect to cost reporting periods of home health agencies ending after September 30, 1981, but the lower limits would be applied in proportion to that part of the agency's cost accounting period occurring after that date.

Nutritional Therapy Under the End Stage Renal Disease
Program (Section 6350)

Present medicare law provides no coverage for nutritional therapy for the treatment of end stage renal disease (ESRD).

The bill would provide coverage under the medicare program for nutritional therapy, when it is used as a means of delaying, or substituting for, the provision of kidney dialysis, for those beneficiaries who would otherwise qualify for medicare benefits.

Nutritional therapy may, in general, be defined as the use of specifically manufactured foods that are of "high biologic value". These foods may help an individual with end stage renal disease to maintain an appropriate level of protein in their diet, while at the same time providing certain essential amino acids and sufficient calories to maintain nitrogen balance.

There is limited evidence that nutritional therapy may delay the necessity for renal dialysis or may result in a reduction in the number of renal dialysis treatments required. The Committee is aware that the use of nutritional therapy in the treatment of end stage renal disease is a new approach and, therefore, expects the Secretary to implement this provision in a manner which will ensure that payment will be made under this provision only where there is evidence that nutritional therapy is cost-effective.

The Committee is concerned that little data is available regarding the costs of nutritional therapy supplies and other costs associated with nutritional therapy, and that nutritional therapy as a treatment modality is in the process of development and change. The Committee expects the Secretary, in consultation with experts in the fields of nephrology and nutrition (especially nutritional therapy) and with suppliers of nutritional

therapy supplies, to establish regulations and guidelines for the coverage of, and reimbursement for, nutritional therapy supplies and related physician and other services.

Under current law, entitlement to benefits under part A of medicare and eligibility to enroll under part B begins with the third month after the month in which a regular course of renal dialysis is initiated. (In addition, eligibility can be established by reason of kidney transplantation). The bill would provide entitlement to benefits beginning with the earlier of the third month after the month in which a regular course of renal dialysis is initiated or the third month after the month in which a regular course of renal dialysis would have been initiated but was not initiated because nutritional therapy was provided. The Committee recognizes the difficulty in fixing a precise date on which renal dialysis would have begun, but expects the Secretary to establish guidelines and regulations to ensure that only those patients with end stage renal disease become eligible for medicare benefits under this provision.

The enactment of this provision shall not be construed as releasing the Secretary from his obligation, under Public Law 96-499, to study and conduct a demonstration project and submit legislative recommendations to the Congress by December 5, 1982, concerning the effectiveness of nutritional therapy in early renal failure in retarding or arresting the progression of the disease with a resultant deferment of dialysis.

The effective date of the section specifies that no person can establish entitlement to benefits under this provision on the basis of nutritional therapy furnished before October 1, 1981.

Section-by-Section Analysis

Section 101. Reduction in Medicaid Payments to States. Federal matching payments to all States would be reduced by 3% in FY 1982, 2% in FY 1983, and 1% in FY 1984. A State could lower its reduction by 1/3 if it (1) has a qualified hospital cost review program; (2) has an unemployment rate greater than 150 percent of the national average; or (3) demonstrates recoveries from fraud and abuse control activities or third party recoveries equalling 1 percent of Federal payments. A State which met all three criteria would experience no reduction in its Federal payments.

Section 102. Hospital Reimbursement Rate Determinations. Eliminates the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid. Requires instead that Medicaid payments be "reasonable and necessary to the efficient and economical delivery of services." Further requires that, by FY 1984, State Medicaid programs use a system under which payment amounts are set on a prospective basis.

Section 103. Competitive Arrangements for Payment for Laboratory Services, Medical Devices, and Drugs. Eliminates recipient "freedom of choice" with respect to lab services, medical supplies, and drugs, and authorizes States to purchase these services through competitive bidding arrangements.

Section 104. Elimination of the EPSDT Penalty. Under current law, States that fail to inform all AFDC families of the availability of EPSDT services, to provide screening upon request, and to arrange for treatment, are subject to a 1% reduction in their Federal match under AFDC program. The bill would repeal this 1% penalty, but would retain the program requirements.

Section 105. Repeal of Required Medicaid Coverage for Individuals Aged 18-21. The bill would repeal the requirement in current law that States provide Medicaid coverage to persons aged 18-21 who would be eligible for AFDC cash assistance if they were attending school. States could, at their option, continue to provide coverage to this population.

Section 106. Waiver of Medicaid Requirements. Authorizes the Secretary to waive those requirements of Medicaid law necessary to allow States to (1) implement a case-management system for primary care, (2) "lock" recipients who chronically overutilize services into a designated provider, (3) share with recipients any cost savings resulting from their use of more cost-effective delivery systems (e.g., HMOs), or (4) exclude from the program those providers that systematically abuse the program. In addition,

the Secretary would be authorized to allow localities to act as central brokers in giving recipients a choice of competing health plans. A waiver request could not be approved if it would substantially impair access to services of adequate quality.

Section 107. Removal of Medicare Reasonable Charge Limitation. Repeals the requirement in current law that State payments to physicians not to exceed Medicare "reasonable charge" levels.

Section 108. Permitting Medicaid Matching for Payments to Promote Closing and Conversion of Underutilized Hospital Facilities. Authorizes States to pay for costs associated with closure or conversion of hospitals (other than those in underserved areas). The Secretary's approval for such payments would be required only where the total reimbursement to the hospital exceeds Medicare "reasonable cost" levels.

Section 109. Options for the Provisions for the Provision of Home and Community-Based Care and Requirement of Pre Admission Screening for Long-Term Care Patients. The bill would authorize States, at their option, to cover a range of non-institutional long-term care services if they can assure the Secretary that the costs of their plans would not exceed the costs of providing long-term care under their current programs. The bill would also require States, by FY 1983, to establish a mechanism to assess recipients seeking nursing home care to determine, prior to admission, their need for such care in light of available alternatives.

Section 110. Encouraging HMO Participation in State Medicaid Plans. Raises the limitation on Medicare and Medicaid enrollment in HMOs participating in Medicaid from 50% of total membership to 75%. In the case of public HMOs, this limitation could be waived entirely. States would also be authorized to negotiate with HMOs to guarantee them minimum enrollment periods of up to 6 months for Medicaid enrollees.

Section 111. Eliminating Federal Matching for Excessive Pre-operative Stays and Unnecessary Tests. Denies Federal matching for (1) a pre-operative hospital stay of more than one day (2) inpatient hospital tests not specifically ordered by the attending physician.

Section 112. Permitting Physician Assistants and Nurse Practitioners to Perform Certain Recertifications. Under current law, Medicaid recipients in SNFs and ICFs must be certified every 60 days as being in need of such services by a physician. The bill would authorize States to allow PAs and NPs to make this recertification.

Section 113. Limitation on Requirement for Collection of Third Party Payments. Authorizes States to forego recovery of third party liabilities for care received by Medicaid recipients in cases where the cost of recovery would exceed the amount that could be recovered.

Section 114. Repeal of Obsolete Authority for Medical Assistance.

Section 115. Study of Federal Medical Assistance Percentage Formula. The bill requires the Comptroller General, in consultation with the Advisory Committee on Intergovernmental Relations, to study the current matching formula and to recommend revisions to Congress by March 31, 1982.

Title II Medicare and Medicaid Changes

Section 201. Elimination of Occupancy Test for Hospital Long-Term Care in Nonpublic Hospitals. Eliminates the occupancy test currently used to determine whether Medicare or Medicaid should reimburse hospitals at the acute care rate or at the lower long-term care rate for inpatients who do not require acute care but for whom no long-term care bed is available in the area. Under current law, reimbursement is not reduced to the lower rate unless hospital's annual occupancy rate is below 80% percent; for Medicaid purposes, this test would be eliminated except in the case of public hospitals.

Section 202. Civil Money Penalties. Authorizes the Secretary to impose, with respect to any Medicare or Medicaid claim determined to be fraudulent, a civil money penalty of up to \$2000 per item and an assessment of up to twice the amount fraudulently claimed. The Secretary would also be authorized to suspend any person determined to have filed a fraudulent claim from the Medicare or Medicaid programs.

Section 203. Limitation on Medicare and Medicaid Payments for Certain Drugs. Prohibits payment under Medicare or Medicaid in the case of drugs where the FDA, after reviewing the recommendations of its expert advisory committees, determines that the drug does not meet the criteria for being safe and effective and issues a notice of an opportunity for a hearing.

Section 204. Withholding of Payments for Certain Medicaid Providers. Authorizes the Secretary to offset, from reimbursements due to Medicare providers, overpayments made to them under Medicaid in cases where they have terminated or substantially reduced their participation in Medicaid.

Section 205. Technical Corrections for Errors Made by the Medicare and Medicaid Amendments of 1980.

Section 211. Making Delegated Review Optional. Eliminates the requirement in current law that PSROs, in determining, whether care provided to Medicare and Medicaid patients is medically necessary, rely on the findings of hospital's utilization review (UR) committee.

Section 212. Assessment of PSRO Performance. Directs the Secretary to assess the relative performance of each PSRO in (1) monitoring the quality

of patient care, (2) reducing unnecessary utilization, and (3) managing its activities effectively. Based on this assessment, the Secretary is authorized to terminate up to one half of current PSROs by the end of FY 1982.

Section 213. Optional Use of PSROs Under State Medicaid Plans. Repeals the current requirement that States generally contract with PSROs to undertake utilization review; allows States, at their option, to use PSROs in carrying out their utilization review responsibilities.

Section 214. Secretarial Determination in Lieu of PSRO Certification. Authorizes the Secretary, or any agent the Secretary designates, to make the determinations as to whether a Medicare or Medicaid patient in a hospital requires acute care or a lower level of care for purposes of determining reimbursement levels (see Section 201).

Section 215. Redesignation of PSRO Areas. Directs the Secretary, in conjunction with the termination of ineffective PSROs, to consolidate PSRO areas so that there are no more than 5 PSROs in any State.

Section 301. Elimination of Carryover from Previous Year of Incurred Expenses for Meeting the Part B Deductible. Under Medicare Part B, beneficiaries are required to incur \$60 annually in expenses for most covered medical services before the program will begin making payments. In determining whether the \$60 deductible has been met, the Secretary now considers expenses incurred in the current calendar year plus those incurred in the last three months of the preceding calendar year. The bill would eliminate consideration of this 3-month carryover from the previous year.

Section 302. Increase In, and Indexing of, Part B Deductible. Increases the \$60 Part B deductible to \$70 in calendar year 1982, and, beginning in 1983, indexes the deductible by the same percentage as the annual Social Security cash benefits increase.

Section 303. Incentive Reimbursement Rate for Renal Dialysis Services. Requires the Secretary to establish prospectively determined reimbursement rates for outpatient renal dialysis under Medicare Part B in order to provide incentives for use of the least costly treatment settings.

Section 304. Limits on Reimbursement to Home Health Agencies. Reduces the limits on reimbursement to home health agencies from the 80th to the 75th percentile of costs per visit.

Section 305. Nutritional Therapy Under End-Stage Renal Disease Program. Authorizes Medicare Part B coverage for nutritional therapy services for end-stage renal disease patients where such therapy serves to eliminate or reduce the need for dialysis treatment.

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3982

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO
SECTION 3 OF THE FIRST CONCURRENT RESOLUTION ON
THE BUDGET FOR FISCAL YEARS 1982, 1983, AND 1984

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY
VIEWS



[R-2]

VOL. III

JUNE 19, 1981.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

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WASHINGTON : 1981

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OMNIBUS RECONCILIATION ACT OF 1981

JUNE 19, 1981.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

Mr. JONES, from the Committee on the Budget,
submitted the following

R E P O R T

[To accompany H.R. 3982]

[Including cost estimates of the Congressional Budget Office]

1. The causal link between increased imports and worker layoffs and production/sales declines in the worker's firm or subdivision is strengthened from the present "contributed importantly" standard to the "substantial cause" standard used for industry-wide import relief.

2. Certain weeks of employer-authorized leave or disability covered by workmen's compensation will be counted toward the minimum pre-layoff employment requirement; the UI extended benefit "suitable work" test is applied to eligibility for TRA payments but not to other assistance.

3. TRA benefits are reduced to State UI levels for a maximum duration of 52 weeks of UI and TRA combined, payable only upon exhaustion of UI during the worker's most recent benefit period; payments are limited to weeks of unemployment more than 60 days after the petition is filed and during the 52 weeks after exhaustion of regular UI; an additional 26 weeks of TRA benefits will be available to workers in training, but not to older workers.

4. Supplemental training assistance and job search and relocation allowances are increased.

5. Training is made an entitlement if certain conditions exist; not less than \$112 million is authorized in each of fiscal years 1982 and 1983 for training, job search and relocation allowances and program evaluation.

FIRM AND COMMUNITY TRADE ADJUSTMENT ASSISTANCE (PARTS B AND C)

Under existing law, individual firms may receive technical and/or financial assistance if they meet the same certification criteria described above for workers and develop an economic adjustment plan approved by the Secretary of Commerce.

Part B of the bill amends the criteria for firm certification to conform to the stricter import causation standard adopted for workers. Other modifications were necessary to preserve the existing program upon its transfer within the Commerce Department from the Economic Development Administration to the International Trade Administration, including authority for pre-certification and industry-wide technical assistance. Minor amendments make loan guarantees more attractive to private lenders and provide greater flexibility in their interest rate. Part C of the bill repeals the trade adjustment assistance program for communities, which has never been utilized.

The worker and firm programs are reauthorized for one year, to terminate September 30, 1983.

B. TITLE II: FEDERAL OLD AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

PHASE OUT STUDENT BENEFITS FOR POSTSECONDARY STUDENTS

Under current law, monthly cash benefits are paid to the children of an insured worker when the worker retires, becomes disabled, or dies. Because of a provision added in 1965 a child's benefits may continue after age 18 and up until age 22 as long as the beneficiary can establish

that he is attending high school, college, or vocational school on a full-time basis. Benefits can continue for several months beyond age 22 (until the end of the school term) if the student has not yet completed his four-year college degree.

The Committee approved a proposal to eliminate the social security student benefit for post-secondary students age 18-22 who first enroll in postsecondary school after December 1982.

Children aged 18-22 currently receiving benefits as full-time students as well as those enrolled in post-secondary school before January 1983 could continue to receive benefits until age 22, but would be precluded from receiving future benefit increases after the 1981 increase, and would receive no payments during the summer months, June through August, except where the student is enrolled in a full-time summer school program beginning in 1982. Also, children over 18 would continue to receive benefits until completion of their elementary or secondary education.

TERMINATION OF MOTHERS' AND FATHERS' BENEFITS WHEN CHILD ATTAINS AGE 16

Under current law, monthly cash benefits are paid to mothers or fathers caring for a child receiving social security benefits until the child attains age 18. The Committee would end entitlement to benefits for mothers and fathers when the child attains age 16.

The provision would not apply in the case of a parent caring for a disabled child aged 16 or over. The provision would be effective with respect to current beneficiaries only at the end of two years after the month of enactment, but would be effective for parents becoming newly entitled in or after the second month after enactment.

ELIMINATE THE SOCIAL SECURITY MINIMUM BENEFIT FOR NEWLY ENTITLED BENEFICIARIES

Under existing law, social security beneficiaries whose average life-time earnings in covered employment are low receive a "minimum benefit" which is higher than the benefit they would otherwise receive under the benefit computation formula. (Low average earnings can result from work at low wages or from a few years attachment to the program.) The 1977 amendments "froze" the initial minimum benefit at \$122 per month for persons who reach age 62, become disabled, or become eligible for survivor benefits after 1978; once they are on the benefit rolls, these beneficiaries receive the cost-of-living increases payable to all social security beneficiaries. Beneficiaries who turned 62, became disabled, or became newly eligible for survivor benefits in 1978 or earlier, receive whatever minimum benefit was in effect at the time they were first eligible to come on the rolls, plus any cost-of-living adjustments.

The Committee approved a proposal to eliminate the minimum benefit for newly-entitled beneficiaries. As of January 1982, no new beneficiaries would receive the minimum benefit, and would instead receive a benefit based strictly on their earnings record. This provision, in contrast to the Administration's proposal, would not affect the 3 million beneficiaries currently relying on their minimum benefits.

ROUND SOCIAL SECURITY BENEFITS

Under present law, at each stage in the benefit computation, the amount derived is rounded up to the next higher 10 cents.

The Committee approved a proposal, effective generally for benefit computations after August 1981, which would provide that the amount derived at each stage in the benefit computation would be rounded to the lower dime, except for the last step—the actual benefit amount payable per beneficiary. This would be rounded to the next lower dollar. For those beneficiaries electing supplemental medical insurance (SMI), the rounding would occur after the SMI premium was deducted from the OASDI benefit check.

PENSION REFORM ACT—COST REIMBURSEMENT

Under current law, provisions of the Pension Reform Act of 1974 require administrators of most employee pension plans to furnish plan participants with information concerning their accrued and vested benefit rights. In addition, employers are required to maintain records, in accordance with Department of Labor regulations, sufficient to determine the benefits which are, or may become, due to each employee. While some pension plans have not kept the necessary earnings information, the Social Security Administration does maintain this information and has already received requests from plans for complete earnings histories of plan members. Under the provisions of the Freedom of Information Act and the Privacy Act, the cost of retrieving and transmitting this information is not fully borne by the requestor. Part is financed out of the social security trust funds.

The Committee approved a provision to permit SSA to recover the full cost of retrieving and transmitting information for purposes of enabling pension plans to comply with the Pension Reform Act. Effective October 1, 1981, full payment would be required from requestors to the social security trust funds for expenses incurred in providing earnings information, if the request is not directly related to determining an individual's social security benefit. Information requested by individuals for social security program purposes records will generally continue to be provided free of charge.

PAY ONE-HALF OF JULY 1982 CPI INCREASE IN JULY, REMAINDER IN OCTOBER

Under existing law, the change in the CPI is measured from the first calendar quarter of one year to the first calendar quarter of the next year. If it shows a 3 percent or more increase, a benefit increase of equivalent amount will be due for the month of June payable in July, following the end of the measuring period. This same increase applies to SSI, Veterans' and Railroad Retirement benefits.

The Committee approved a provision which moved part of the payment of the cost-of-living increase to October instead of July in 1982. An ad hoc increase equal to one-half the increase in the cost-of-living from the first quarter of 1981 to the first quarter of 1982 would be paid in July 1982.

In October 1982, a second benefit increase would be computed based on the increase in the CPI from the first quarter of 1981 to the March through May period of 1982 (a 14-month inflation period as compared to the present 12-month period). This increase would be adjusted to reflect the ad hoc increase paid in July, so that the October increase plus the ad hoc increase in July would equal the increase in the CPI over the 14-month measuring period. In this way, beneficiaries would receive a total increase based on 14 months of inflation, from January 1981 to March 1982. Future automatic increases, after 1982, would be based on the CPI change in the March through May period each year, and would be paid in October of each year.

TRUST FUND FINANCING FOR SUCCESSFUL VOCATIONAL REHABILITATION SERVICES

Under existing law, a limited amount of trust fund money can be used to pay States for vocational rehabilitation services (VR) provided to beneficiaries.

The Committee repealed the program that provides social security trust funds for the rehabilitation of disabled social security beneficiaries. However, the States would be provided reimbursement for rehabilitation services provided to disabled beneficiaries if they engage for nine continuous months in substantial gainful activity (SGA).

RETAIN SOCIAL SECURITY RETIREMENT TEST EXEMPT AGE AT 72 THROUGH 1982

Under current law, the age at which the retirement test no longer applies is scheduled to drop to 70 in January 1982. The provision would delay that change until January 1983.

RESTRICT SOCIAL SECURITY PAYMENT OF LUMP-SUM DEATH BENEFITS

Under current law a lump-sum death payment of \$255 is payable when a worker who is fully or currently insured dies.

If there is a surviving spouse living with the worker at the time of death, the lump-sum payment is paid to that person. If there is no widow or widower eligible to receive the lump-sum death payment, the money can be paid to the person who assumed responsibility for funeral expenses.

The Committee agreed to eliminate the lump-sum death payment effective October 1981 in cases where there is no eligible spouse or entitled child. Under the proposal, a surviving spouse or child (under age 18) who is eligible (or would be eligible, in the case of a surviving spouse, but for their age) to receive monthly cash survivor benefits upon the worker's death would receive the lump-sum death payment.

MODIFICATION OF MONTH OF INITIAL ENTITLEMENT FOR CERTAIN WORKERS AND THEIR DEPENDENTS

Under the current law, social security benefits are paid for the entire month in which a person becomes eligible for the benefits,

even if the date of eligibility is in the middle or the end of the month. The Committee approved a provision which would allow payment of benefits for certain workers and their dependents only for months in which conditions of eligibility are met for the entire month. This provision would be effective for months after August 1981.

C. TITLE III: UNEMPLOYMENT COMPENSATION, PUBLIC ASSISTANCE, LOW INCOME ENERGY ASSISTANCE AND SOCIAL SERVICES PROVISIONS

UNEMPLOYMENT COMPENSATION

ELIMINATION OF THE NATIONAL TRIGGER FOR THE EXTENDED BENEFITS PROGRAM

Under existing law, up to 13 additional weeks of unemployment benefits, beyond the usual maximum duration of 26 weeks of State benefits, become payable to unemployed workers in times of high unemployment. Fifty percent of the costs of these extended benefits are paid from the proceeds of the Federal unemployment tax and fifty percent from State taxes. Extended benefits are paid in a State when the insured unemployment rate in the State reaches 4 percent and, in addition, is 20 percent higher than it was during the same period in the previous two years. Thirty-nine States provide for the payment of extended benefits when their insured unemployment rate reaches 5 percent, regardless of unemployment levels in previous years. Extended benefits are paid in *all* States, regardless of State unemployment rates, when the national insured unemployment rate reaches 4.5 percent. This is referred to as the "national extended benefits trigger."

Section 301 would repeal the national trigger, so that extended benefits would be paid only in States with insured rates above the specified levels, effective upon enactment.

EXCLUDE EXTENDED BENEFITS CLAIMANTS FROM STATE TRIGGER CALCULATIONS

Under current law, the insured unemployment rate—used to determine unemployment levels for the purpose of triggering extended benefits—is calculated by dividing the number of individuals receiving regular-State or extended benefits by the total number of workers covered under the State unemployment law.

Section 302 would exclude extended benefits claimants from the calculation of the insured unemployment rate for extended benefits trigger purposes effective July 1, 1981.

CHANGES IN UNEMPLOYMENT COMPENSATION REQUIREMENTS FOR EX-MILITARY PERSONNEL

Under present law, Federally funded unemployment benefits are provided to former military personnel upon their separation from military service if they meet the qualifying requirements of the State

in which they apply for unemployment compensation. The military service of the individual qualifies as wages or employment in the determination of eligibility under the State unemployment compensation law only if (1) the person had served continuously for 1 year or more prior to separation and (2) the individual was separated under other than dishonorable or bad-conduct circumstances.

Section 303 would increase to 2 years the period of continuous active military service an individual must have in order for his or her military service to qualify as employment for unemployment compensation purposes; prohibit eligibility for unemployment compensation until 4 weeks after separation from the military; and, limit the number of weeks of unemployment compensation based on military service to 13. This provision is effective with respect to new claims filed on or after October 1, 1981.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

LIMIT EARNED INCOME DISREGARDS

Under current law, in determining AFDC benefits, States reduce a family's monthly payment by the amount of any earnings that remain after the following disregards are applied: (1) the first \$30, plus one-third of additional earnings; and (2) any expenses (including child care) reasonably attributable to the earning of any such income. (The work expense disregard is available to both recipients and new applicants. The \$30 and one-third applies only to those already on the rolls.)

Section 321 would require States to disregard the following amount of monthly earnings, effective October 1, 1981:

For determining eligibility, 20 percent of gross earnings up to a maximum of \$175 per month; and child care costs up to a monthly maximum of \$200 per child and \$400 per family.

For determining benefits, \$50; 20 percent of gross earnings up to \$175 per month; child care costs up to \$200 per child and \$400 per family per month; and, one-third of remaining earnings.

For two-parent families, States could limit the disregards to 20 percent of gross earnings (up to \$175 per month) for eligibility determination; and \$50 plus 20 percent of gross earnings (up to \$175 per month) for benefit calculation.

States could terminate, or phase-out gradually, the \$50 disregard and the one-third work incentive disregard for families with earned income above the poverty level or, at State option, 200 percent of the State standard of need, after the family has had earned income and claimed one-third disregard for 12 consecutive months. Individuals who lose eligibility for AFDC payments because of the termination of the disregards would remain eligible for Medicaid for 12 months after payment stops.

COUNT INCOME OF STEPPARENT

Under existing law, States are prohibited from assuming the income of a stepparent is available to an AFDC child unless, under State law, stepparents are required to support stepchildren to the same extent

that natural parents are required to support their children. In most States, a stepparent's income can be counted only in cases in which the welfare agency receives information that the income is available to an AFDC child. However, States are allowed to prorate AFDC shelter and utility benefits when an eligible child lives with a relative, including a stepparent, who is not an AFDC recipient, as long as the total income exceeds the State's standard of need.

Section 322 would require States to consider available to a child that portion of the income of a child's stepparent (living in the same home as the child) which exceeds (1) 20 percent of earnings, (2) an amount equal to the State standard of need for the stepparent and others living in the same household whom he claims as dependents for Federal income tax purposes, (3) amounts actually paid by the stepparent to dependents not living in the same household, and (4) payments of alimony or child support to individuals not living in his household. A State would have the option of establishing a procedure and the conditions under which the State could determine that a stepparent's income is not available to the children and, therefore, not make the reduction in benefits. Effective October 1, 1981.

REQUIRE RETROSPECTIVE ACCOUNTING AND MONTHLY REPORTING

Under Federal regulations, each State may choose to pay benefits "retrospectively" (make payments after a month has ended on the basis of the person's income during the month) or "prospectively" (make payments during or before a month based on what the recipient's circumstances are expected to be during that month). The Federal statute makes no mention of how frequently AFDC recipients must submit reports to the welfare agency.

Section 323 would require States to determine monthly benefits "retrospectively" on the basis of the actual income of the previous month. Eligibility would be determined "prospectively" on the basis of current month's circumstances. And, for the first month of a family's eligibility, benefits would be determined on current month's circumstances. States would have to require all recipients to provide monthly reports on income, family composition, resources, etc.

The Secretary could allow a State to require less frequent reporting for specified classes of recipients, if the State demonstrates the administrative cost of monthly reporting for such recipients is not worthwhile. The provisions would be effective on October 1, 1981. However, until October 1, 1983, the Secretary could waive any penalty for non-compliance if he determines that a State is taking the necessary steps to implement retrospective accounting and monthly reporting.

ALLOW STATES TO REQUIRE CERTAIN RECIPIENTS TO PARTICIPATE IN JOB SEARCH AND EXPERIENCE ASSIGNMENTS

Under existing law, recipients of Aid to Families with Dependent Children (AFDC) are required to register for participation in the Work Incentive (WIN) program unless they fall within certain exempt categories specified in the Federal statute (e.g., mothers caring for children under age 6). Under the WIN program, recipients are required to accept available employment or training in order to receive AFDC payments. State are not now allowed to establish alternative

work requirements which do not conform closely to the WIN program.

Section 324 would allow States to require AFDC recipients to participate in work experience assignments in which they would perform work in return for AFDC benefits. All employable recipients who are not in school or participating in a WIN or other approved training or work-related program, and who are working less than 20 hours a week, could be required to participate in work assignments after a WIN appraisal and an employability plan (or similar procedures established by the State) had been completed. Adequate day care would have to be available for recipients who need it.

Eligible participants could be required to work for up to 96 hours a month or, if less, the number of hours obtained by dividing their monthly AFDC payment by the minimum wage. In addition to the work assignment, each participant would be required, and must be provided necessary assistance and a reasonable period of time, to seek permanent employment or appropriate training. The State would have to reimburse participants for reasonable and necessary expenses incurred in connection with a work experience assignment and job search requirements.

Work experience assignments would have to be consistent with the physical capacity, skills, experience, health, family responsibilities and place of residence of the participant; meet health and safety standards specified by the Secretary of HHS; and could not displace permanent employees or jobs.

These provisions are effective October 1, 1981 through October 1, 1987.

DEFINE AN UNEMPLOYED PARENT (UP) AS THE PARENT WHO IS THE PRINCIPAL EARNER FOR THE FAMILY

Under present law, States have the option to provide AFDC-UP benefits to families where both parents are in the home and one is unemployed. Only one parent must be unemployed to meet this eligibility requirement; the other parent may be employed.

Section 325 would limit eligibility for AFDC to those two-parent families in which the "principal earner" (the parent with the most earnings in the 24 month period prior to application) is unemployed, effective October 1, 1981.

REQUIRE STATES TO RECOVER AFDC OVERPAYMENTS AND PAY UNDERPAYMENTS

Current Federal law does not require States to recover overpayments or make a retroactive reimbursement for any underpayments. By regulation, States are given the option of recouping overpayments. However, if a State recovers overpayments, it must also pay underpayments.

Section 326 would require States to promptly take all necessary steps to correct any overpayments or underpayments. Recovery of overpayments would be made from current assistance payments, available income, or through legal processes. In the case of a current recipient, the amount recovered in any month could not exceed the

amount that would reduce the family's grant below 90 percent of the benefit for a family of the same size. This provision is effective October 1, 1981.

OPTIONAL PAYMENTS FOR DEPENDENT CHILDREN AGE 18 AND OVER AND IN SCHOOL

Under present law, to be eligible for AFDC as a dependent child, the general rule is that the person must be under 18 years of age. States have the option, however, of continuing benefits through age 20 if the person is regularly attending high school, vocational school or college. Currently 43 States extend AFDC eligibility to students age 18 through 20. These States may limit benefits to those attending high school and vocational schools; but they must continue benefits through age 20 if the person remains in school.

Section 327 would allow States who pay benefits to dependent children over 18 years of age (because they are in school) to limit eligibility at any age between 18 and 21, effective October 1, 1981.

DEEM SPONSORS' INCOME TO ALIENS IN AFDC FAMILIES

Current Federal law does not require States to consider the income of a sponsor of an alien legally admitted to the U.S. as income available to the alien for AFDC program purposes.

Section 328 would restrict AFDC payments to citizens of the U.S. and lawfully admitted aliens. In addition, the income and resources of the sponsor would be considered available to an alien in an AFDC family for three years after his or her entry into the U.S. The provision would be applicable with respect to individuals applying for aid for the first time after October 1, 1981.

LIMITATION ON RESOURCES

Under present law, States are required to take into consideration any resources of a child or relative in determining eligibility for AFDC benefits. States are allowed to exclude certain resources, including a home, personal effects, an automobile and income-producing property. Regulations require States to deny benefits to any individual whose assets minus the exclusions exceed \$2,000.

Section 329 would reduce the current \$2,000 per recipient limit on resources to \$1,500 per family. States would be allowed to exclude a home and a car; household and personal effects; life and burial insurance policies; tools, equipment and other income-producing property. States would also be allowed to continue to delay eligibility for AFDC in cases where assets were disposed of in order to qualify for benefits, as under current law. This provision is effective October 1, 1981.

CHILD SUPPORT ENFORCEMENT

COLLECTION OF SUPPORT FOR ADULTS

Under current law, a State child support agency is not authorized to collect support (i.e., alimony) on behalf of a parent of a child for whom it is collecting child support. This is the case even when a

court has ordered a single amount for both the parent and the child, without specifying the amount payable on behalf of each.

Section 331 would make State child support enforcement agencies responsible for collecting support for adults, in the case of a parent of a child for whom it is collecting child support and in those cases in which the support obligation has already been established, in the same manner as for child support. This provision is effective upon enactment.

MODIFY COLLECTION FEE FOR NON-AFDC FAMILIES

Under existing law, States are required to provide services to non-AFDC families requesting assistance. States have the option of charging a fee of up to \$20 and of retaining a portion of the child support payments to recover costs of administration in excess of the application fee.

Section 332 would require States to charge a fee equal to 10 percent of the support collected for non-AFDC recipients to defray costs of the child support enforcement agency collection services. The fee would be retained by the State. This provision is effective upon enactment.

SOURCE OF INCENTIVE PAYMENTS TO COOPERATING JURISDICTIONS

Under current law, the 15 percent incentive payments to States or political subdivisions that collect child support payments on behalf of another jurisdiction are taken from the Federal share of the amount collected.

Section 333 would provide that the 15 percent incentive payments to States and political subdivisions would come from the full amount of collections, rather than from the Federal share, effective October 1, 1981.

CHILD SUPPORT OBLIGATIONS NOT DISCHARGED BY BANKRUPTCY

In 1974, a provision was included in the child support enforcement program which prohibited the discharge in bankruptcy of a child support obligation which had been assigned to a State as a condition of AFDC eligibility. This Social Security Act provision was subsequently repealed by section 328 of Public Law 95-598 (the 1978 revision of the Bankruptcy Act).

Section 334 would reinstate the provision previously in effect which provides that a child support obligation assigned to a State as a condition of AFDC eligibility is not discharged in bankruptcy, effective upon enactment.

CHILD SUPPORT INTERCEPT OF UNEMPLOYMENT BENEFITS

Under existing law, there is no provision allowing for the withholding of unemployment benefits in cases of outstanding child support obligations.

Section 335 would require child support enforcement agencies to determine on a periodic basis whether any individuals receiving un-

employment compensation or trade adjustment assistance benefits owe child support obligations. The agency would be required to collect any outstanding child support obligations owed by an individual receiving unemployment benefits, through an agreement with the individual or the legal processes of the State, by having a portion of the person's unemployment benefits withheld and forwarded to the child support agency by the unemployment compensation agency. This provision is effective October 1, 1981; but the provisions would not become State Child Support Enforcement and Unemployment Compensation plan requirements until October 1, 1982.

INTERNAL REVENUE SERVICE COLLECTION OF CHILD SUPPORT AND ALIMONY

Under current law, a State may request the IRS to collect delinquent, court-ordered child support payments after the State has made diligent and reasonable efforts to collect the payments. The amount of the child support obligation must be certified by the Secretary of Health and Human Services before IRS collection procedures may be used.

Section 336, at the request of a State and subject to the same certification and other requirements in current law, would (1) allow IRS to collect delinquent alimony as well as child support payments where alimony and child support are combined in a single order and the amounts for child support and alimony are not identified; and (2) permit IRS collections in cases where child support/alimony obligations have been established under an administrative as well as court order. This provision is effective upon enactment.

SUPPLEMENTAL SECURITY INCOME (SSI)

RETROSPECTIVE ACCOUNTING FOR SSI RECIPIENTS

Currently, SSI benefits are determined on the basis of income anticipated to be available in the current calendar quarter. Redeterminations are made at such times as provided by the Secretary.

Section 341 would provide that SSI benefits be based on actual income of the previous month (or, at the Secretary's option, the circumstances in effect on the last day of the second previous month). Eligibility would be based on current month's circumstances. And, for the first month benefits are received, and for any month in which significant change occurs in the living arrangements of the individual, benefits would be based on current month's circumstances. This provision is effective for months after the last month of the first quarter ending five months after enactment.

ELIGIBILITY OF SSI RECIPIENTS FOR FOOD STAMPS

Under current law, SSI recipients in three States—Massachusetts, Wisconsin and California—receive a cash payment, as a part of the State supplemental SSI benefits, in lieu of food stamps. Massachusetts and Wisconsin are allowed to provide SSI recipients cash in lieu of food stamps because, and for so long as, the Federal Government continues to contribute to the cost of the State supplemental benefit as pro-

vided under the "hold harmless" provisions in present SSI law. A separate Federal law allows California to continue to "cash-out" food stamps for SSI recipients so long as it continues to pass-through each year the Federal SSI cost-of-living increase and provides a yearly cost-of-living adjustment in its State supplementary benefit.

Section 342 would modify current Federal SSI food Stamp "cash-out" requirements so that a State could continue to "cash-out" food stamps for SSI recipients so long as it (1) had previously increased its supplementary benefits to include the bonus value of food stamps, (2) was providing a cash payment in lieu of food stamps as of December 1980, and (3) continued to pass-through the Federal cost-of-living increases as required under section 1618 of current SSI law. This provision is effective July 1, 1981.

NEGOTIABILITY OF SSI CHECK

Under existing law there is no time limit on the negotiability of SSI checks.

Section 342 would limit the negotiability of SSI checks to 180 days from date of issuance. The amount of any unnegotiated checks which represents a State supplementary payment would be returned to the States. This provision is effective October 1, 1981.

SPECIAL INTERIM COST-OF-LIVING INCREASE IN SSI BENEFITS

A yearly cost-of-living adjustment is made in Federal SSI benefits equal to the percentage adjustment provided for social security retirement and disability insurance payments. This is done through a reference in the SSI law to the cost-of-living adjustment provisions in Title II of the Social Security Act.

Section 344 would conform future cost-of-living adjustments in SSI to changes in the Social Security cost-of-living adjustment provisions contained in Title II of this bill.

LOW-INCOME ENERGY ASSISTANCE

REAUTHORIZATION OF LOW-INCOME ENERGY ASSISTANCE

Under current law, authority for providing low-income energy assistance (LIEA) exists under both the Economic Opportunity Act of 1964 and the Home Energy Assistance Act of 1980 (Title III of the Crude Oil Windfall Profits Tax of 1980 (P.L. 96-223)). The Economic Opportunity Act does not specify a specific budget authority. The Home Energy Assistance Act authorizes \$3.125 billion for energy assistance in fiscal year 1981. The authority under both acts expires on September 30, 1981. For fiscal year 1981, \$1.85 billion was appropriated for LIEA under the authority of the Economic Opportunity Act of 1964. However, the fiscal year 1981 appropriation stipulates that LIEA is to be administered under the "terms and conditions" of the regulations and any "non-formula amendments thereto" published in the May 30, 1980 Federal Register pursuant to the Home Energy Assistance Act of 1980.

Section 361 would authorize the LIEA funds under a new title XXI of the Social Security Act: \$1.4 billion for FY 1982 and \$1.6 billion for FY 1983. Each State would receive the same proportion of Federal LIEA funds appropriated for fiscal years 1982 and 1983 that it received of the LIEA funds allotted by formula for fiscal year 1981. States would be allowed to carry-over up to 25 percent of the funds received in one fiscal year into the next. Beginning in fiscal year 1983, States would be required to provide 20 percent matching funds.

Federal LIEA funds could be used to provide assistance to families receiving federally funded public assistance benefits (AFDC, SSI, Food Stamps, Veterans' Benefits) and to other families with incomes below 150 percent of the poverty level or 60 percent of State median income. (States could establish income limits below either of these). Payments could be made directly to eligible households, or to energy suppliers or certain building operators, or any combination thereof.

States could use Federal LIEA funds to assist eligible households pay for the costs of heating or cooling; for the purchase and installation of weatherization materials designed to improve the heating or cooling efficiency of homes of eligible households; and to meet energy-related emergency needs, including provision of in-kind benefits.

SOCIAL SERVICES AMENDMENTS

LIMIT FEDERAL TITLE XX TRAINING FUNDS TO \$75 MILLION FOR FISCAL YEAR 1982

Under current law, 75 percent Federal matching funds are available to States for training costs related to Title XX Social Services activities. Beginning in fiscal year 1982, States will be reimbursed only for those expenditures included in an HHS approved State Title XX training plan.

Section 381 would continue through fiscal year 1982 the \$75 million limitation on Federal Title XX training funds that was in effect in fiscal year 1981. States will receive the same share of the \$75 million in fiscal year 1982 as they received in fiscal year 1981.

D. TITLE IV: HEALTH SAVINGS

The bill achieves health savings through changes in medicare reimbursement, benefits, deductibles and coinsurance amounts, and through more efficient program administration.

Medicare reimbursement limits on inpatient hospital and home health services would be tightened, an incentive reimbursement system for renal dialysis services would be established, interest earnings on funded depreciation accounts of providers would be offset against interest expense in determining reimbursement, rules regarding reduced payment for long-term care in hospitals would be tightened, and a provision of existing law postponing reimbursement to certain hospitals at the end of fiscal year 1981 would be repealed.

Nutritional therapy services for end stage renal disease patients would be covered where such therapy postpones or reduces the need

for renal dialysis. Alcohol detoxification facilities would no longer be recognized as medicare providers of services.

Deductible and coinsurance amounts under medicare part A (hospital insurance) would be changed to more nearly reflect current hospital costs, and a coinsurance amount of \$1 per day would be established for the first through the 60th day of inpatient hospital care. The annual deductible for medicare part B (supplementary medical insurance) would be increased from \$60 to \$70 and indexed in future years to reflect cost of living increases. Expenses incurred in the last 3 months of a year could no longer be used to satisfy the part B deductible in the next year.

The Secretary of Health and Human Services would be authorized to impose civil money penalties on persons who file fraudulent medicare or medicaid claims, surveys of skilled nursing facilities would be permitted to be conducted less frequently than annually, and utilization guidelines would be established for coverage of home health services.

Authority would be given to the Secretary to terminate the less effective Professional Standards Review Organizations during fiscal year 1982, and the PSRO program would be repealed at the end of fiscal year 1983.

Medicare part B would become the secondary payor to the Federal Employees Health Benefits Program for people aged 65 and over who have coverage under both programs. Medicare part A would become secondary payor to the Federal employees program with respect to people reaching age 65 on or after January 1, 1982.

SUMMARY OF COMMITTEE RECOMMENDATIONS

REDUCTION IN OUTLAYS

[By fiscal years, in millions of dollars]

	1982	1983	1984
Trade.....	1,370	877	640
Social security.....	3,160	2,608	3,828
Unemployment compensation.....	1,378	540	280
AFDC and child support enforcement.....	691	938	1,002
SSI.....	167	138	146
Low-income energy assistance.....	847	947	1,067
Social and child welfare services.....	7	0	0
Medicare.....	1,642	1,405	1,645
Total, spending reductions.....	9,262	7,453	8,608

(265)

which contains trade secrets or commercial or financial information concerning the operation or competitive position of any business.

Section 126 also adds a provision to section 257 of existing law that direct loans or loan guarantees for the acquisition or development of real property or other capital assets shall ordinarily be secured by a first lien on the assets to be financed and shall be fully amortized. While the Government should attempt to obtain the preferred position on the collateral securing the loan or guarantee, the Secretary may make exceptions to these standards if necessary to achieve the objectives of the program as long as he develops appropriate criteria to protect U.S. interests.

d. Repeal of Transitional Provisions; Conforming Amendments; Effective Date (Sections 127, 129, and 130)

Sections 127, 129, and 130 of the bill repeal the transitional provisions under section 263 of the Trade Act, make conforming amendments to the Trade Act, and provide an effective date and transitional provisions for the amendments in the firm adjustment assistance program.

3. PART C: TRADE ADJUSTMENT ASSISTANCE FOR COMMUNITIES; PROGRAM REAUTHORIZATION

a. Repeal of Adjustment Assistance Program for Communities (Section 141)

Section 141 of the bill repeals the trade adjustment assistance program for communities under Chapter 4 of Title II of the Trade Act as of the date of enactment of this Title. The program has never been utilized, some assistance to trade-impacted communities having been provided instead under the more flexible criteria of Title IX of the PWEDA.

b. Reauthorization of Adjustment Assistance Programs for Workers and Firms (Section 142)

Section 142 of the bill reauthorizes the trade adjustment assistance programs for workers and firms for one year by amending their termination date under section 284 of the Trade Act from September 30, 1982 to September 30, 1983.

B. Title II: Federal Old-Age, Survivors, and Disability Insurance Programs

1. PHASE-OUT OF POST-SECONDARY STUDENT BENEFITS (SECTION 201)

PRESENT LAW AND BACKGROUND

A student's benefit is payable to an unmarried child or eligible grandchild of a retired or disabled worker or of a deceased worker who was fully or currently insured if the child is a full-time student aged 18-21 or reaches age 22 before completing a semester or quarter.

EXPLANATION OF PROVISION

Section 201 of the bill would amend the provisions of the Social Security Act dealing with child's benefits to phase out over a 4-year period, beginning in January 1983, benefits to children between the ages of 18 and 22 because of their full-time attendance as students at institutions of higher education or other post-secondary schools. Children who are currently aged 18-22 and receiving benefits as full-time students as well as those who are enrolled as full-time post-secondary students in December 1982 or a prior month could continue to receive benefits until age 22, but would be precluded from receiving future benefit increases after the 1981 increase, and beginning in 1982 would receive no payments during the summer months, June through August, unless the student is enrolled in a full-time summer school program. A full-time "summer school program" will be defined in regulations established by the Secretary of Health and Human Services as one which requires attendance of at least 15 days in any 2 of the 3 summer months, June through August. Children age 18 and below would not be affected by any changes made by this provision. Also, children over 18 would continue to receive benefits until completion of their elementary or secondary education. Where the benefits of a family containing a post-secondary student are limited by the family maximum amount, the dollars resulting from reduction or elimination of the student's benefit will be re-distributed to the other family members up to the family maximum amount.

The Committee feels that the post-secondary student benefit does not coordinate with educational assistance programs that have been developed since the student benefit was established by legislation enacted in 1965. Educational assistance is granted more equitably and efficiently through those other Federal student aid programs. Your Committee also feels, however, that adequate notice of this change must be given families who may have anticipated receiving these benefits in the future.

2. TERMINATION OF MOTHERS' AND FATHERS' BENEFITS WHEN CHILD ATTAINS AGE 16 (SECTION 202)

PRESENT LAW AND BACKGROUND

A monthly benefit is paid to a widow (widower) or surviving divorced mother (father) if (1) the deceased worker on whose account the benefit is paid was fully or currently insured at time of death and (2) widow (widower) or surviving divorced mother (father) has 1 or more entitled children of the worker in her (his) care. These payments continue until the youngest child being cared for reaches age 18.

EXPLANATION OF PROVISION

Section 202 of the bill would end entitlement to benefits for the mother or father caring for a child who receives child's insurance benefits, when the child reaches age 16 (rather than age 18, as under current law). The provision would not apply in the case of a parent

caring for a disabled child aged 16 or over. The provision would be effective with respect to current beneficiaries only at the end of two years after the month of enactment, but would be effective for parents becoming newly entitled in or after the second month after enactment. Benefits to the child or children in the family would continue until age 18 as under present law (or 22 as prescribed under section 201 of the bill).

Present law provides a parent's benefit on the assumption that the parent cannot work away from the home while a child under the age of 18 is in her (his) care. The Committee proposed this change in recognition of the fact that the extent of parental care ordinarily required for a child who is not disabled and is age 16 or over does not make it impracticable for the parent to work. The Committee feels, therefore, there is insufficient justification for continuing to provide these parents with social security benefits since it can be presumed they will be able to provide for their own support.

3. ELIMINATION OF MINIMUM BENEFIT LEVEL (SECTION 203)

PRESENT LAW AND BACKGROUND

Social security benefits are based on the worker's record of earnings under social security over his working career. Under current law for workers turning 62 after December 1978, if a worker's earnings record would produce a benefit less than \$122 per month, the worker is awarded a minimum benefit of \$122. If the worker is taking a reduced benefit before age 65, the benefit is reduced accordingly. Once the worker is on the benefit rolls at the minimum benefit level, the benefit is increased by the cost-of-living increases applicable to all social security benefits.

EXPLANATION OF PROVISION

Section 203 would eliminate the minimum payment floor for beneficiaries first becoming eligible for benefits after December 1981. Beneficiaries becoming eligible after that date would receive a benefit based strictly on their earnings record, and would continue to receive cost-of-living increases once on the benefit rolls.

The original purpose of the minimum was to raise retirement income for those with very low wage histories, as well as those who worked in jobs before social security was extended to their work. In the opinion of your Committee, the minimum benefit has outlived its usefulness and can generate windfall benefits to workers with substantial earnings not covered by social security. Criticism of the windfall aspect of the minimum has been growing because the minimum is increasingly going to people who were not primarily dependent on earnings from covered employment.

In general, low-paid workers who worked regularly under the social security program would not be disadvantaged if the minimum were eliminated. A regular worker retiring this year with lifetime earnings equal to the prevailing Federal minimum wage each year would get benefits substantially higher than the minimum. Also, the special minimum benefit provision for long-term, low-income workers would provide higher benefits for that group of workers.

Eliminating the minimum emphasizes that the Supplemental Security Income (SSI) program is an appropriate source of income for needy aged, blind, or disabled people. Those social security beneficiaries who qualify for the relatively lower benefit in the future who are needy could receive SSI to a greater extent at age 65 and after than is true today. The Committee believes that this is a more efficient and appropriate method of dealing with the problem of poverty for those who have only a marginal attachment to work covered by social security.

However, your Committee also felt that it would be both inequitable and administratively difficult to eliminate the minimum benefit for current beneficiaries. Those current beneficiaries who would not qualify for SSI benefits or have the reduction in their benefits replaced by other family benefits would suffer an arbitrary and precipitous loss of income at a time when their ability or resources to replace this income may be minimal. In addition, your Committee has substantial doubts that these beneficiaries could be located in a timely manner and is concerned that the administrative difficulties in locating these individuals and individually recomputing their benefits would impose an unreasonable burden on the Social Security Administration and its data processing capabilities.

4. ROUND BENEFITS TO LOWER DIME AND DOLLAR (SECTION 204)

PRESENT LAW AND BACKGROUND

Social security benefit amounts are rounded up to the higher 10 cents at each stage of computing the benefit.

EXPLANATION OF PROVISION

Section 204 provides for rounding benefit amounts down to the lower ten cents at each stage of computing benefits, except at the last step—the actual benefit amount payable per beneficiary. This would be rounded to the next lower dollar. For those beneficiaries electing supplementary medical insurance (SMI), the rounding would occur after the SMI premium was deducted from the OASDI benefit check. This provision applies to benefit amounts, including cost of living adjustments and benefit recomputations, computed after August, 1981.

5. REQUESTS FOR INFORMATION—COST REIMBURSEMENT (SECTION 205)

PRESENT LAW AND BACKGROUND

Provisions of the Pension Reform Act require administrators of most employee pension plans to furnish plan participants information concerning their accrued and vested benefit rights. In addition, employers are required to maintain records, in accordance with Department of Labor regulations, sufficient to determine the benefits which are, or may become, due to each employee. While some pension plans do not have the earnings information necessary to provide the required information, the Department of Health and Human Services

does maintain it and has already received requests from some plans for complete earnings histories of plan members. The Department estimates that there will be requests for about 710,000 individual earnings histories during the next five years at an estimated cost of \$35.5 million.

EXPLANATION OF PROVISION

Section 205 of the bill would make clear that reimbursement of these costs is not governed by the Freedom of Information Act or by the Privacy Act, which contain provisions limiting the extent to which the cost of furnishing information can be recovered. Under the provisions of these Acts, it is estimated that the allowable reimbursement would be no more than \$7.5 million over the next five years. Thus, the cost to the social security trust funds over the same period would be \$28 million. Section 205 would permit the Department to recover from the requesting party the full cost of retrieving and transmitting information for purposes of enabling pension plans to comply with the Pension Reform Act.

In addition to instances of furnishing information under the Pension Reform Act, there are instances where information furnished by the Department of Health and Human Services comes under the same restrictions as to full cost reimbursement because of the limitations in the Freedom of Information Act and the Privacy Act. Section 205 of the bill provides that the Department would have authority to recover the full cost of retrieving and transmitting any information requested for any other purpose not directly related to the administration of the program or programs under the Social Security Act. This authority, of course, would not be used to recover the full cost of furnishing to individuals information requested for social security program purposes. Changes made by this subsection are effective on date of enactment.

6. TRANSITION TO COST-OF-LIVING INCREASES ON A FISCAL YEAR BASIS (SECTION 206)

PRESENT LAW AND BACKGROUND

The cost-of-living increase provision enacted in December 1973 intentionally put the benefit increase on a fiscal year basis in order to avoid creating a substantial outlay increase in the fiscal year 1974 budget. The fiscal year at that time was on a July to June basis. In 1977, the fiscal year was moved to an October to September basis, but the month in which the benefit increase is provided was not similarly changed.

EXPLANATION OF PROVISION

Section 206 of the bill provides for moving the payment of the cost-of-living increase to October instead of July 1982. In addition, it provides that an ad hoc increase would be paid in July 1982 which would be equal to one-half the increase in the cost-of-living from the first quarter of 1981 to the first quarter of 1982.

In October, 1982 a second benefit increase would be computed based on the increase in the CPI from the first quarter of 1981 to the March

through May period of 1982 (a fourteen-month inflation period as compared to the present 12-month period) and the remainder of the benefit increase equal to this amount would be paid. The October increase plus the ad hoc increase in July would equal the increase in the CPI over the 14-month measuring period. In this way, beneficiaries would receive a total increase based on 14 months of inflation, from January 1981 to March of 1982. Future automatic increases after 1982 would be based on the CPI change in the March through May period each year and would be payable in October of each year, restoring the payment to the first month of the fiscal year. The changes made by this section would also make corresponding changes in the cost of living adjustments provided under Tier I and the survivors and spouses's maximum benefits of Tier II of the Railroad Retirement Service, and under the needs-tested veterans' pension programs.

7. REIMBURSEMENT OF STATES FOR SUCCESSFUL REHABILITATION SERVICES (SECTION 207)

PRESENT LAW AND BACKGROUND

Under existing law, an amount equal to 1.5 percent of disability insurance expenditures is authorized to be expended from the social security trust funds for vocational rehabilitation. In recent years much less than this has been requested by the Administration and appropriated by the Congress.

EXPLANATION OF PROVISION

Section 207 of the bill would eliminate reimbursement from the trust funds to the state vocational rehabilitation agencies for rehabilitation services except in cases where the services have resulted in the beneficiary's performance of substantial gainful activity for a continuous period of 9 months. Such nine month period could begin while the individual is under a vocational rehabilitation (VR) program and may also coincide with the trial work period and during the individual's waiting period for benefits. The services must be performed under a State plan for vocational rehabilitation service under title I of the Rehabilitation Act (or its successor plan if rehabilitation services are transferred to the States under the President's block grant proposal). In the case of any State which is unwilling to participate or which does have a plan which meets the requirements of the Vocational Rehabilitation Act, the Commissioner may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The determination that the VR services contributed to the successful return of the individual to work and the determination of the costs to reimburse shall be made by the Commissioner of Social Security, in consultation with the Commissioner, Rehabilitation Service Administration, Department of Education, in accordance with criteria formulated by the Commissioner of Social Security, Post-employment services, including administration, counseling and placement costs would also be subject to reimbursement.

Changes made by this section are effective for services provided after October 1, 1981.

Your Committee believes that the responsibility for the rehabilitation of severely disabled persons lies primarily with the basic rehabilitation grant program and should not be financed in any major way by the social security trust funds. However, by providing trust fund reimbursement for services where it can be demonstrated that services resulted in the disabled person leaving the benefit rolls, your Committee believes the bill gives rehabilitation agencies sufficient incentive to attempt rehabilitation of social security disability beneficiaries.

8. TEMPORARY EXTENSION OF EARNINGS LIMITATION TO INCLUDE ALL PERSONS AGED LESS THAN 72 (SECTION 208)

PRESENT LAW AND BACKGROUND

Under present law in effect through the end of 1981) the earnings test applies until the month a worker reaches age 72. Under a provision of the 1977 Social Security Amendments, the age at which the test no longer applies is scheduled to be reduced to 70 beginning in 1982.

EXPLANATION OF PROVISION

Section 208 of the bill would keep the exempt age under the earnings test at age 72 for 1982. Beginning in 1983 it would be lowered to age 70.

9. RESTRICTION ON PAYMENT OF THE LUMP SUM DEATH BENEFIT (SECTION 209)

PRESENT LAW AND BACKGROUND

A lump sum death payment of \$255 is payable on the death of a fully or currently insured worker to the surviving spouse or to the person or persons who assume responsibility for funeral expenses. Application for the lump sum death payment must be made within the two-year period ending with the second anniversary of the insured person's death. The lump sum death payment is paid to the deceased person's widow (or widower) if she (he) was living with the deceased when the insured person died. In the absence of such a surviving spouse, the lump sum death payment is paid on application to the individual who assumes responsibility for the payment of the burial expense of the deceased. If no one assumes responsibility for the payment of the burial expenses incurred through a funeral home within 90 days after the insured person died, the lump sum death payment is paid to the funeral home upon application.

EXPLANATION OF PROVISION

Section 209 would eliminate the lump sum death payment effective for deaths occurring after August, 1981 in cases where there is neither an eligible spouse nor an entitled child. Under the proposal only surviving spouses who are eligible, or would be eligible but for their age, to receive monthly cash survivor benefits upon the worker's death would receive the lump sum death payment. If there were no eligible

spouse, the lump sum of death payment would be payable to any young child of the deceased worker who was eligible to receive monthly cash benefits as a surviving child. If there were no surviving spouse and the worker's children were all over 18 (or over 21 if full-time students), then no one would be eligible to receive the lump sum death payment.

The lump sum death payment has been frozen since 1954. Because it was intended only to provide a modest assistance in the worker's last illness and death and has a marginal relation to the basic social security program, your Committee feels this payment no longer meets the goals for which it was originally intended except in cases where the payment is made to a surviving spouse or child.

10. MODIFICATION OF MONTH OF INITIAL ENTITLEMENT FOR CERTAIN WORKERS AND THEIR DEPENDENTS (SECTION 210)

PRESENT LAW AND BACKGROUND

Under present law, social security benefits are payable for the whole month in which the beneficiary meets all requirements for eligibility, regardless of the point in the month the person actually became eligible (for example, if a worker reaches age 62 on June 15, he is eligible to receive a reduced benefit for the month of June.)

EXPLANATION OF PROVISION

Section 210 of the bill provides that in the case of workers retiring at age 62 and in the case of dependents (retiring at age 62) of retired workers, entitlement to benefits would begin with the first month throughout all of which the individual met all the requirements for eligibility. In the example above, the first month of eligibility would be July, and the worker's benefit would reflect 35 months of actuarial reduction, rather than 36. This change would not affect the disabled and their dependents who become entitled at the same time as the worker, although it would apply to dependents who came onto the benefit rolls at some point after the disabled worker becomes entitled. The bill would not affect entitlement to survivors' benefits, to reduced benefits for workers retiring after the month in which they attain age 62, to unreduced benefits in the month (and later months) that an otherwise entitled individual attains age 65, or to Medicare benefits. This provision is effective for months after August 1981.

C. TITLE III: UNEMPLOYMENT COMPENSATION, PUBLIC ASSISTANCE, AND LOW-INCOME ENERGY ASSISTANCE

1. PART A: UNEMPLOYMENT COMPENSATION AMENDMENTS

a. Elimination of National Trigger (Section 301)

PRESENT LAW AND BACKGROUND

Under current law, up to 13 additional weeks of extended unemployment compensation, beyond the usual maximum of 26 weeks of State benefits, are payable to unemployed individuals who exhaust their State benefits during periods of high unemployment. Extended benefits are payable in any State in which the insured unemployment

rate (IUR—the percentage of workers covered by the State unemployment compensation program who are currently claiming State or extended benefits) is 4 percent or higher and, in addition, is 20 percent higher than it was during the same period in the previous two years. When the “20 percent” factor is not met, a State, at its option, may provide extended benefits when the State IUR reaches 5 percent, regardless of the rate in previous years. Thirty-nine States currently use this 5 percent optional trigger rate. Extended benefits are paid in all States, regardless of State unemployment rates, when the national IUR reaches 4.5 percent. This is referred to as the “national extended benefits trigger.”

Fifty percent of the costs of extended benefits are paid from proceeds of the Federal unemployment tax and fifty percent are paid from State unemployment taxes.

EXPLANATION OF PROVISION

Section 301 would repeal the national trigger, so that extended benefits would be payable only in those States with insured unemployment rates as specified above. The provision would be effective for weeks beginning after the date of enactment.

b. Claims for Extended or Additional Compensation Not Included in Determining Rate of Insured Unemployment (Section 302)

PRESENT LAW AND BACKGROUND

Under current law, the insured unemployment rate (IUR)—used to determine unemployment levels for the purpose of triggering “on” extended unemployment compensation benefits—is calculated by dividing the average weekly number of individuals filing unemployment claims (including individuals filing claims for extended benefits) by the average monthly covered employment for the first four of the most recent six calendar quarters.

EXPLANATION OF PROVISION

Section 302 would exclude extended benefit claimants from the calculation of the IUR for extended benefits trigger purposes. Only individuals filing claims for regular unemployment compensation would be included in calculating extended benefits trigger rates.

The provision would be effective for weeks beginning after the date of enactment. For purposes of making IUR determinations for such weeks, the provision would be deemed to have been in effect for all weeks whether beginning before, on, or after the date of enactment. In order to reflect comparable averages for prior years, a State would have to adjust its prior IUR percentages.

c. Limitations on Unemployment Benefits Paid to Ex-Servicemen (Section 303)

PRESENT LAW AND BACKGROUND

Under current law, Federally funded unemployment benefits are provided to former military personnel upon their separation from

military service if they meet the eligibility requirements of the State in which they apply for unemployment compensation. The military service of an individual qualifies as wages or employment in the determination of eligibility only if the person has served 365 or more continuous days (unless separated in a shorter period because of a service incurred injury or disability) and was separated under other than dishonorable conditions, for bad conduct or for the good of the service.

EXPLANATION OF PROVISION

Section 303 would increase from 365 to 730 days the length of continuous military service needed to qualify as employment for unemployment compensation purposes; require a four-week waiting period between the week in which an individual is separated from the military and the week in which he or she first becomes entitled to compensation; and limit an eligible ex-servicemember's total entitlement (including extended benefits) to no more than 13 times the weekly benefit amount payable for total unemployment. The provision would be effective with regard to new claims filed on or after October 1, 1981.

2. PART B: AID TO FAMILIES WITH DEPENDENT CHILDREN; CHILD SUPPORT ENFORCEMENT

a. Limitation and Standardization of Earnings Disregards (Section 321)

PRESENT LAW AND BACKGROUND

Under current law, in making an initial determination of a family's eligibility for Aid to Families with Dependent Children (AFDC), there is disregarded from earned income any expense reasonably attributable to the earning of income, including child day care costs. In determining the amount of benefits to which an eligible family is entitled, there is disregarded from earned income the first \$30 of monthly earnings, plus one-third of remaining earnings, plus child day care costs and other reasonable work-related expenses. After these deductions, whatever income remains is used to reduce the amount of the AFDC grant. The "work-incentive" disregard (\$30 plus one-third) applies only to those already receiving assistance, and does not apply to individuals who terminate or refuse employment without good cause, or who fail to report their earnings.

EXPLANATION OF PROVISION

Section 321 would increase the \$30 per month disregard to \$50; standardize and limit the work expense disregard; place a ceiling on child care costs; change the order of the "one third" disregard so it applies only to earnings remaining after all other disregards have been applied; and allow States to terminate or reduce the \$50 and one-third disregards for families with earnings in excess of the poverty level (or, at State option, 200 percent of the State standard of need).

The provision would require States to disregard the following amount of earnings, in the following order:

(a) *Eligibility Determination.*—20 percent of gross earnings (monthly wages, salary or net earnings from self employment), plus the full amount of any costs incurred in producing self-employment income, up to a maximum of \$175; child care costs up to \$200 per child and \$400 per family per month.

(b) *Benefit calculation.*—\$50; 20 percent of gross earnings up to \$175 per month; child care costs up to \$200 per child and \$400 per family per month; and one-third of remaining earnings.

For two-parent AFDC families, the provision would allow States to limit the disregards to 20 percent of gross earnings (up to \$175 per month) for eligibility determination; and \$50 plus 20 percent of gross earnings (up to \$175 per month) for benefit calculation.

In addition, the provision would allow States to terminate, or phase-out gradually, the \$50 and one-third work incentive disregards for families with earned income above the poverty level or, at State option, 200 percent of the State standard of need, after the family has had earned income and claimed the one-third disregard for a 12 month period.

Once applied, the reduction or termination of the \$50 and one-third disregards could continue to be applied only so long as the earned income of the family continues to remain above the poverty level (or 200 percent of the State standard of need, if this option is selected). Except, in the case of a family that continues to receive AFDC, a State could continue the reduction or termination of the disregards for up to four months during which the earned income of the family was below poverty (or 200 percent of the State standard of need). In the case of a family to which the reduction or termination of the disregards has been applied and who loses eligibility for AFDC because countable earnings exceed the State payment level, the State could continue the reduction or termination of the disregards for four consecutive months following the loss of AFDC eligibility, if the family's earnings remain in excess of the poverty level (or 200 percent of the State standard of need).

Individuals who lose eligibility for AFDC payments because of the reduction or termination of the \$50 and one-third disregards would remain eligible for Medicaid for 12 months after AFDC benefits cease.

The provision would become effective October 1, 1981.

b. Income of Stepparents (Section 322)

PRESENT LAW AND BACKGROUND

Under current law States are prohibited from assuming that the income of a stepparent is available to an AFDC child unless, under State law, stepparents are required to support stepchildren to the same extent that natural parents are required to support their children. Generally, income may only be counted in cases in which the welfare agency has received information that the stepparent's income is available to an AFDC child. However, States are allowed to prorate AFDC shelter and utility benefits when an eligible child lives with a relative, including a stepparent, who is not an AFDC recipient—as long as the total income exceeds the State's standard of need.

EXPLANATION OF PROVISION

Section 322 would require States to consider available to a child that portion of the income of a child's stepparent (living in the same home as the child) which exceeds (1) 20 percent of earnings, (2) an amount equal to the State standard of need for a family of the same composition as the stepparent and others living in the same household whom he claims as dependents for Federal income tax purposes, (3) amounts actually paid by the stepparent to dependents not living in the same household, and (4) payments of alimony or child support to individuals not living in his household. A State would have the option of establishing procedures and conditions under which the State could determine that a stepparent's income is not actually available to the children and, therefore, not make the reduction in benefits. The provision in current law which allows States to prorate shelter and utility benefits when a child lives with an ineligible relative could not be applied in cases where benefits are reduced as a result of this requirement. The provision would be effective October 1, 1981.

c. Retrospective Budgeting and Monthly Reporting (Section 323)

PRESENT LAW AND BACKGROUND

Current law does not specify a particular accounting period for determining AFDC eligibility and benefits, except that a person's income must be considered on a monthly basis. Federal statute also makes no mention of how frequently AFDC recipients must submit reports to the welfare agency. Under Federal regulations, however, each State may choose to pay "retrospectively" or "prospectively." "Retrospectively" means paying a recipient after a month has ended on the basis of the person's income during the month. "Prospectively" means paying a recipient during or before a month, based on what the recipient's circumstances are expected to be during that month.

If a State uses retrospective accounting, it must require monthly income reports from recipients with earned income, and may require reports from other recipients. As of March 1981, 12 States use the retrospective accounting method: Arizona, California, Idaho, Illinois, Kansas, Michigan, Montana, North Dakota, Oregon, South Dakota, Washington, and Wyoming. This method is also used in parts of Colorado. In addition, Minnesota, Missouri and Utah require monthly reports from those with earnings and with work histories, but use a prospective accounting method.

EXPLANATION OF PROVISION

Section 323 would require all States to determine monthly benefits retrospectively on the basis of the actual income of the previous month. (Eligibility would be determined on the basis of current month's circumstances.) For the first month of a family's eligibility, however, benefits would be determined on the current month's circumstances.

States would have to require all AFDC families to report monthly on income, resources and other factors which may affect eligibility or amount of payment. However, the Secretary could allow a State to

require less frequent reporting for specified classes of recipients, if the State demonstrated the administrative cost of monthly reporting for such recipients would not be worthwhile. States would be required to take prompt action to adjust or terminate assistance on the basis of the report, or upon the failure of the family to furnish a timely report.

The provision also provides that, in any case where a determination is made to terminate, suspend, adjust (for overpayment), withhold, or reduce payment to a family, the family must be mailed a written notice of that action at least 10 days before the date the action is to become effective. The notice must include a statement of the action to be taken, the reasons and specific legal basis (including citation of applicable law and regulation) for the action, and the family's right to request a hearing and the circumstances under which payment will be continued if a hearing is requested. Such notice need not be mailed 10 days before the action is taken, but may be mailed to arrive no later than the date regularly designated for delivery of the payment affected by the action, in certain specified circumstances described in the provision.

A hearing (which may be a hearing before the State agency or an evidentiary hearing at the local level with a right to appeal to a State agency hearing) must be granted to any family that requests it, if the request is made within 90 days after notice of the reduction or termination of benefits has been mailed. As under current regulation, any such hearing would have to be consistent with the protections established by the Supreme Court in the case *Goldberg v. Kelly*. If the family requests a hearing within 10 days after the date on which adverse action is taken, payment must be either continued in full (where the request is made on or before that date) or reinstated in full in as short a time as possible but in any event within five days, and the action must be revoked until the hearing decision is issued. These payments would be subject to recovery or adjustment if the agency's action is sustained in the hearing process.

The section would be effective October 1, 1981. However, until October 1, 1983, the Secretary could waive the penalty for noncompliance with the retrospective accounting and monthly reporting requirements if he determines that a State is taking the necessary steps to implement them.

d. Assistance to Families Participating in State Work Experience Programs (Section 324)

PRESENT LAW AND BACKGROUND

Under current law, recipients of Aid to Families with Dependent Children are required to register for participation in the Work Incentive (WIN) program unless they fall within certain specified exempt categories (e.g., mothers caring for children under age 6). Under the WIN program, recipients are required to register for available employment or training in order to receive AFDC payments. Interpretation of Federal law by the Department of Health and Human Services prohibits States from using Federal AFDC matching funds for grants to persons who are required to perform work in return for AFDC benefits.

EXPLANATION OF PROVISION

Section 324 would establish specific conditions under which payments to AFDC recipients who participate in State "work experience programs" would be eligible for Federal matching funds, and would allow States to require certain AFDC recipients to participate in work experience assignments in which they would perform work in return for AFDC benefits. The Committee does not intend that this provision be interpreted as requiring States to establish a work experience program, or as requiring a State to have a work experience program in effect throughout the State. Furthermore, States would not be mandated to require all eligible AFDC recipients in the State to participate in a work experience program. Payments made to individuals participating in approved State work experience programs would continue to be considered AFDC benefits, and would not be considered wages for any purpose.

To be eligible for Federal matching funds, state work experience programs would have to ensure that work assignments take into account the physical capacity, skills, and experience of participants, and are appropriate in terms of the participants' health, family responsibilities, places of residence, and need for child care. Participants would have to be supervised and assignments would have to be monitored. The program must also ensure that participants will, to the extent feasible, be treated in the same manner as permanent employees with whom they are working. The Committee does not intend that this provision be interpreted as requiring eligibility for pension plans, unemployment insurance, or other similar benefits which may be available to persons with regular employee status; but rather that the work activities of participants be integrated with those of regular employees to the extent possible.

Under the provision, participants would be assigned work only if it is to be performed for a State or local public agency or a non-profit organization. Work assignments would have to serve a useful public purpose, consist of work which would not otherwise be performed, and meet appropriate health and safety standards.

Work assignments could not displace permanent employees or jobs. No individual could fill a job opening as part of a work experience assignment when another person not participating in such an assignment is on lay-off from the same job or from a substantially equivalent job with the same employer; or when the job opening exists because the employer has terminated the employment of a regular employee or otherwise reduced his workforce with the intention of filling the opening with a work experience assignment participant.

The provision limits the number of hours a participant may work to no more than 8 hours during any day, and no more than 96 hours a month; or, if less, the number of hours obtained by dividing the participant's monthly AFDC grant by the highest of the wage rates provided by applicable Federal, State, or local minimum wage laws. (If no such law is applicable, the Federal minimum wage rate as set forth in section 6(a)(1) of the Fair Labor Standards Act of 1938 would apply.) If a participant incurred reasonable and necessary work expenses due to his or her participation in a work experience assignment or job search activities, the State would be required to promptly reimburse the individual for such expenses.

Prior to referral to a work experience assignment, each individual would have to be appraised and have an employability plan developed as part of the WIN program or of a State-established program having substantially the same conditions and requirements. The provision would require that participants be given reasonable time (beyond the time actually working) to seek permanent employment, or available training to qualify for permanent employment, and be referred to permanent employment opportunities which become available during their participation in a work experience assignment. Furthermore, necessary and available counseling and job search assistance must be provided to participants.

An AFDC recipient would be exempt from participation only if he or she was (1) enrolled and attending full time in a school, college, or course of vocational training, or participating in a WIN program; (2) incapacitated; (3) age 65 or older; (4) a caretaker in the home where another member of the household requires the caretaker's presence because of the individual's illness or incapacity; or (5) currently employed for more than 20 hours a week.

If an individual who is not exempt from participation refuses to accept a work experience assignment, fails to report to or carry out such assignment, or fails to participate in job search as a part of or in addition to such assignment without good cause, the needs of that individual may not be taken into account in determining the family's AFDC benefit for such period as the Secretary (or the State in accordance with regulations of the Secretary) may specify in light of the nature and duration of the refusal or failure and the circumstances of the participant.

Federal matching funds would be available for State administrative costs, as specified by the Secretary. Such costs would not include amounts spent for materials or equipment.

The provision would be effective October 1, 1981, through October 1, 1987.

e. Eligibility for AFDC by Reason of Unemployment of Parent Who Is Family's Principal Earner (Section 325)

PRESENT LAW AND BACKGROUND

In 1961 Congress enacted temporary legislation allowing States at their option to provide assistance to families in which a parent was unemployed. In 1967 this legislation was made permanent, but eligibility was limited to families in which only the father was unemployed. In 1979 the Supreme Court held in *Califano v. Westcott* that the restriction to fathers was discriminatory. Since that time, the Department has been operating under an "unemployed parent" concept, and either parent may qualify as the unemployed parent, regardless of whether the other parent is employed.

EXPLANATION OF PROVISION

Section 325 would provide for eligibility (at the option of the State) for an unemployed parent, and would define an unemployed parent as the parent with the greater amount of earnings in the 24-month period immediately preceding application.

The provision would be effective October 1, 1981.

f. Adjustments for Incorrect Payments (Section 326)

PRESENT LAW AND BACKGROUND

Current law contains no provisions specifying how States are to treat overpayments and underpayments. In practice, States are allowed, but not required, to collect overpayments. Regulations prohibit recoupment of overpayments unless the recipient has income or resources, exclusive of the assistance payment, currently available in the amount by which the agency proposes to reduce payments. Thus, if the individual has no income or countable resource in excess of the AFDC payment, there can be no recovery of overpayments. There is one exception to this provision. Recoupment may be made where the overpayments were caused by the recipient's willful withholding of information concerning his income, resources, or other relevant circumstances. In such cases, the agency may recover, but, if recoupment is from current assistance payments, the State must do so in such a way as not to cause undue hardship to recipients.

States are also required by regulations to have provisions for prompt correction of underpayments to current recipients resulting from administrative error where the State plan provides for recoupment of overpayments. Corrective payments need not be made where the administrative cost would exceed the amount of the payment. Corrective payments may not be considered as income or resources for purposes of determining the recipient's continue eligibility and amount of assistance.

EXPLANATION OF PROVISION

Section 326 would require States to promptly take all necessary steps to correct any overpayments or underpayments. Recovery of overpayments would be made from current assistance payments, available income, or through legal processes. In the case of a current recipient, the amount recovered in any month could not exceed the amount, when added to the family's income, that would reduce the family's grant below 90 percent of the benefit for a family of the same size with no other income. A corrective payment of an underpayment could not be considered as income, and could not be considered a resource until the beginning of the second full month following receipt. The provision would be effective October 1, 1981.

g. Benefits for Dependent Children Who Are Age 18 or Over and In School (Section 327)

PRESENT LAW AND BACKGROUND

Under current law, States have options for establishing the maximum age of a dependent child eligible for assistance. States may choose to limit eligibility to a child who is under age 18 or may define a dependent child to include students age 18 through 20 who are regularly attending primary, secondary, vocational school, or college. At the present time, 43 States extend AFDC eligibility to students age 18

through 20. However, many States have chosen this option solely to enable them to include secondary school students over age 17.

EXPLANATION OF PROVISION

Section 327 would allow States who pay benefits to dependent children over 18 years of age (because they are in school) to limit eligibility at any age between 18 and 21. It is the Committee's intent to increase the flexibility of States in determining such individual's eligibility for benefits. At present, if a State wants to provide benefits on behalf of any "child" age 18 and over, it must provide them to all who meet the eligibility requirements, up to age 21. In other words, the State may not set the age limit at under 19 or under 20. The provision would continue to require the State to provide assistance on behalf of eligible children under age 18, but would allow the State to set the age limit for students at such higher age (not above 21) as it may specify.

The provision would also give States flexibility to establish different age limits for students in different kinds of school settings. States would be permitted to establish special conditions for the completion of educational or training activities, and to limit eligibility to attendance at specified types or levels of institutions or courses.

The provision would be effective October 1, 1981.

h. Eligibility of Aliens for AFDC (Section 328)

PRESENT LAW AND BACKGROUND

Under current law and regulations in order for an alien to be eligible for AFDC payments, he must be lawfully admitted for permanent residence or otherwise permanently residing in the United States "under color of law." An alien seeking admission to the United States must establish that he is not likely to become a public charge. If a visa applicant does not have sufficient resources of his own, a U.S. consular officer may require assurance from a resident of the United States that the alien will be supported by a "sponsor" in the United States. However, under current law, the income of a sponsor of an alien legally admitted to the U.S. is not counted as income available to the alien under the AFDC program.

EXPLANATION OF PROVISION

Section 328 would provide that, for purposes of eligibility for AFDC, legally admitted aliens who apply for benefits for the first time after September 30, 1981 would be deemed to have the income and resources of their immigration sponsors available for their support for a period of 3 years after their entry into the United States. The eligibility of such aliens for AFDC would be contingent upon their obtaining the cooperation of their sponsors in providing the necessary information to the State welfare agency to carry out this provision. The alien and sponsor would be jointly and severally liable for repayment of any benefits incorrectly paid because of misinformation provided by the sponsor or because of his failure to report, and any such incorrect

payments not paid would be withheld from any subsequent payments for which the alien or sponsor would otherwise be eligible under the Social Security Act.

In deeming a sponsor's income to an alien under this provision, the alien's AFDC benefit would be reduced by the amount of any income deemed to him. Income deemed to the alien would be considered unearned income and would result in a dollar-for-dollar reduction in benefits. The amount to be deemed would be equal to the total monthly amount of earned and unearned income of the sponsor and the sponsor's spouse reduced by an amount equal to the sum of (1) the lesser of 20 percent of earned income, or \$175; (2) the standard of need of the State for a family of the same size and composition as the sponsor and other individuals claimed by him as dependent (for Federal tax purposes) who are living in the same household as the sponsor; (3) any amounts paid by the sponsor to individuals not living in the household who are claimed as dependents (for Federal tax purposes) and (4) any payments of alimony or child support with respect to individuals not living in the household.

The amount of resources deemed to the alien would be equal to the amount of the resources of the sponsor and spouse as determined under the State's AFDC resource rules, reduced by \$1,500.

Under the provision, an alien applying for SSI would be required to make available to the State agency any documentation concerning his income or resources or those of his sponsor (if he has one) which he provided in support of his immigration application. The Secretary of Health and Human Services would be authorized to obtain copies of any such documentation from other agencies (i.e., State Department or Immigration and Naturalization Service), and to provide the information, upon request, to a State agency. The Secretary of HHS would also be required to enter into cooperative arrangements with the State Department and the Justice Department to assure that persons sponsoring the immigration of aliens are informed at the time of sponsorship that, if the alien applies for AFDC, the sponsorship affidavit will be made available to the public assistance agency and the sponsor may be required to provide further information concerning his income and assets in connection with the alien's application for assistance.

Under the provision, the income and resources of a sponsor which are deemed to an alien in a family would not be considered in determining the need of other, non-sponsored family members (e.g. a child born after entry into the U.S.) except to the extent such income or resources are actually available to them.

The provision would not apply to any alien who is (1) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a) (7) of the Immigration and Nationality Act; (2) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207 (c) (1) of such Act; (3) paroled into the United States as a refugee under section 212(d) (5) of such Act; (4) granted political asylum by the Attorney General under Section 208 of such Act; or (5) a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.

i. Limitation on Resources (Section 329)

PRESENT LAW AND BACKGROUND

Under current law, in determining need for assistance, States are required to take into consideration any resources of a child or relative claiming assistance. Regulations allow States to exclude certain types and amounts of resources. These include an individual's home, personal effects, automobile and income producing property. In addition, the amount of real and personal property, including liquid assets, which a State is allowed to exclude may not exceed \$2,000 for each individual recipient. States may allow reasonable proportions of income from businesses or farms to be used to increase capital assets, so that income may be increased. Regulations formerly required only that resources be "reasonably evaluated." However, as a result of court action, resources must now be valued on the basis of equity value, rather than fair market value.

EXPLANATION OF PROVISION

Section 329 would reduce the \$2,000 per recipient limit on resources contained in regulations to \$1,500 per family (or lower, at State option). States would also be allowed to continue to exclude a home and a car; household and personal effects; life and burial insurance policies; tools, equipment and other income producing property; and such other noncash items as the State excluded on the day prior to the date of enactment of the bill. States would be allowed to continue to delay eligibility for AFDC in cases where assets were disposed of in order to qualify for benefits, as under current law. The provision would be effective October 1, 1981.

j. Collection of Support for Certain Adults Receiving AFDC (Section 331)

PRESENT LAW AND BACKGROUND

Under current law, applicants for, and recipients of, AFDC are required to assign all rights of support, including alimony, to the State for collection. However, Title IV-D of the Social Security Act only specifies that child support is to be collected. A State child support agency is not authorized to collect support (i.e., alimony) on behalf of a parent of a child for whom it is collecting child support. This is the case even when a court has ordered a single amount for both the parent and the child, without specifying the amount payable on behalf of each.

EXPLANATION OF PROVISION

Section 331 would permit the collection of alimony under Title IV-D of the Act. State child support enforcement agencies would be responsible for collecting support for adults, in those cases in which the support obligation has already been established, in the same manner as for child support.

The provision would be effective upon enactment.

k. Cost of Collection and Other Services for Non-AFDC Families (Section 332)

PRESENT LAW AND BACKGROUND

Under current law, States are required to provide child support collection services to non-AFDC families requesting assistance. States have the option of charging a fee up to \$20 and of retaining a portion of the child support payments to recover costs of administration in excess of the application fee.

EXPLANATION OF PROVISION

Section 331 would require States to charge a fee equal to 10 percent of the support collected for non-AFDC recipients who use the child support enforcement agency collection services. The fee would be retained by the State. The provision would continue to permit the State to charge an application fee for other services that do not involve collection of support, such as establishing paternity or locating an absent parent. Under the provision, State claims for Federal financial participation under Title IV-D of the Act would be reduced by the total amount of fees charged or other income resulting from services provided by the child support agency.

The provision would be effective October 1, 1981.

l. Source of Incentive Payments to Cooperating Jurisdictions (Section 333)

PRESENT LAW AND BACKGROUND

Under current law, a 15 percent incentive payment is paid to States or political subdivisions that collect child support payments on behalf of another jurisdiction, financed entirely from the Federal share of the amount collected.

EXPLANATION OF PROVISION

Section 333 would require that incentive payments to States and political subdivisions come from the full amount of collections, rather than from the Federal share. The provision would require that the 15 percent incentive payment be reduced prior to the distribution of the balance of the amount collected as provided in section 457 of the Act.

The provision would be effective October 1, 1981.

m. Child Support Obligations Not Discharged in Bankruptcy (Section 334)

PRESENT LAW AND BACKGROUND

Under current law, child support obligations may be discharged in bankruptcy proceedings.

In 1974, legislation was enacted (Public Law 93-674) which prohibited the discharge in bankruptcy a child support obligation which had been assigned to a State as a condition of AFDC eligibility. This Social Security Act provision was subsequently repealed by section 328 of Public Law 95-598 (the 1978 revision of the Bankruptcy Act).

EXPLANATION OF PROVISION

Section 334 would reinstate the provision previously in effect which prohibits the discharge in bankruptcy a child support obligation assigned to a State as a condition AFDC eligibility. The provision would be effective upon enactment.

n. Child Support Intercept of Unemployment Benefits (Section 335)

PRESENT LAW AND BACKGROUND

Current Federal law requires the State agency charged with the administration of the State unemployment compensation law to disclose wage and other information related to the receipt of State unemployment compensation benefits, upon request and on a reimbursable basis, to any State or local child support enforcement agency. Under current law, there is no Federal requirement that unemployment benefits be withheld in cases of outstanding child support obligations. Some States do have such requirements in their State unemployment compensation laws or, as a matter of administrative practice, withhold from unemployment benefits amounts garnished for child support.

EXPLANATION OF PROVISION

Section 335 would require child support enforcement agencies to determine on a periodic basis whether any individuals who owe child support obligations enforceable by the agency are receiving unemployment compensation or trade adjustment assistance benefits (under chapter 2 of the Trade Act of 1974). The child support enforcement agency would be required to collect any outstanding child support obligations owed by an individual receiving unemployment benefits—through an agreement with the individual or, in the absence thereof, the legal processes of the State—by having a portion of the individual's unemployment benefits withheld and forwarded to the State child support agency. As a condition for receipt of Federal administrative grants under title III of the Social Security Act, agencies charged with the administration of the State unemployment compensation laws would be required to withhold and forward to the child support agency the amount of the individual's unemployment benefits specified in the agreement or otherwise required to be withheld as a result of legal process. An agreement to withhold less than the full amount owed would not excuse the individual's legal obligation. Amounts withheld would be forwarded to the child support agency.

Section 335 would require the State unemployment compensation agency to ask all new applicants for unemployment compensation to

disclose whether they owe child support that is paid through any State or local agency or court (i.e., support obligations assigned to and or being enforced by the child support agency). If the applicant owes such support and is found eligible for unemployment benefits, the State unemployment agency must notify the appropriate State or local child support agency pursuant to section 454 of the Social Security Act. The provision would require the child support agency to reimburse the State unemployment agency for administrative costs incurred attributable to its participation in child support enforcement activities.

The provision would be effective upon enactment, but would not be a State unemployment compensation or child support enforcement plan requirement under sections 303 and 454 of the Social Security Act until October 1, 1982.

o. Internal Revenue Service Collection of Child Support and Alimony (Section 336)

PRESENT LAW AND BACKGROUND

Under current law, a State may request the Internal Revenue Service (IRS) to collect delinquent, court-ordered child support payments after the State has made diligent and reasonable efforts to collect the payments. Current law restricts IRS collection to delinquent "child support," although some court orders establish a single amount to be paid which includes alimony. The amount of the child support obligation must be certified by the Secretary of Health and Human Services before IRS collection procedures may be used.

Fourteen States have laws which establish an administrative process for establishing and enforcing child support obligations as an alternative to traditional court proceedings. These State laws provide due process of law by requiring notice, opportunity for a hearing, right to counsel and the opportunity to appeal to a court of law.

EXPLANATION OF PROVISION

Section 336 would permit the IRS, at the request of a State and subject to the same certification and other requirements in current law, to collect delinquent alimony as well as child support payments where alimony and child support are combined in a single order and the amounts for child support and alimony are not separately identified. The provision would also permit IRS collections in cases where child support/alimony obligations have been established under an administrative as well as court order (i.e. a rule or administrative adjudication by the appropriate State agency).

Under current law, States must pay a fee to the Federal government for each case referred to IRS for collection. Currently these fees are being deposited in the general fund of the U.S. Section 336 makes clear the Committee's intent that these reimbursements should be credited to the accounts of the Department of Treasury so that the IRS can be directly reimbursed for the costs associated with making those collections.

The provision would be effective upon enactment.

3. PART C: SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS

a. Retrospective Budgeting for SSI Benefits (Section 341)

PRESENT LAW AND BACKGROUND

Under current law, computation of SSI eligibility and amount of benefits is based on the income and resources for the calendar quarter. However, if the initial application for benefits is made during the second or third month of a calendar quarter, eligibility for and amount of benefits is calculated on the basis of the circumstances in that month. When an individual enters a hospital or other medical institution in which a major part of the bill is paid by the medicaid program, beginning with the first full calendar month the individual is in such institution, his monthly SSI benefit standard is reduced to \$25.

EXPLANATION OF PROVISION

Section 341 provides that the computation period for determination of eligibility and amount of SSI benefits will be on a monthly basis. In most cases, benefits would be determined on a monthly retrospective basis; that is, the amount of the benefit for a month would be determined on the basis of income, resources, and other characteristics in the preceding month or, at the discretion of the Secretary of Health and Human Services, the second preceding month.

Under the provision, there would be certain exceptions to the monthly retrospective computation period. Eligibility would be based on the current month's circumstances. The amount of SSI benefits for the month in which the application is filed, or for the first month following a month of ineligibility, would be based on the income and other circumstances in the month for which the benefit is being determined. The Secretary would have discretion to extend this manner of computation of benefits to the month following the month in which the application is filed and to the second month following a month of ineligibility. For any month in which a significant change in living arrangements occurs (as determined by the Secretary), the amount of benefit would also be determined on the basis of the income and other relevant circumstances in the month for which the benefit is being determined.

The provision would also provide authority for the Secretary of HHS to waive retrospective accounting in the case of individuals in certain medical institutions in order to promote the individual's removal from a medical institution and into a less restrictive living arrangement more appropriate to his or her situation. The Secretary could use this waiver authority if he finds that it would promote the individual's removal in the following month from an institution to a less restrictive living arrangement. Thus, in some instances, the Secretary would have the authority to waive the reduction in the monthly benefit standard to \$25 if a higher payment level would enable the individual to maintain a household to which he could be expected to return upon his release from the medical institution.

The section would provide authority for the Secretary to make a transitional payment or payments during the first two months for which the amendments made by this section are effective.

This section would be effective for months after the last month in the first calendar quarter ending at least five months after the month in which the bill is enacted.

b. Eligibility of SSI Recipients for Food Stamps (Section 342)

PRESENT LAW AND BACKGROUND

Under current law, SSI recipients in three States—Massachusetts, Wisconsin and California—receive a cash payment, as a part of the State supplemental SSI benefits, in lieu of food stamps. Massachusetts and Wisconsin are allowed to provide SSI recipients cash in lieu of food stamps because, and for so long as, the Federal Government continues to contribute to the cost of the State supplemental benefits as provided under the “hold harmless” provisions in present SSI law. (The SSI statute protects States—holds them harmless—from increased costs resulting from Federal eligibility and benefit requirements.) When California lost its hold harmless status, a separate law was enacted to allow it to continue to “cash-out” food stamps for SSI recipients so long as it continues to pass-through each year the Federal SSI cost-of-living increase and provides a yearly cost-of-living adjustment in its State supplemental benefit.

EXPLANATION OF PROVISION

Section 342 provides that, if a State cashed out food stamps for SSI recipients in December, 1980 and continues to meet the requirements for passing through the Federal cost-of-living increases in SSI, it may continue to provide cash in lieu of food stamps for SSI recipients.

c. Negotiability of SSI Checks (Section 343)

PRESENT LAW AND BACKGROUND

Under current Federal law there is no time limit on the negotiability of U.S. Treasury checks issued for the purpose of providing SSI benefits. When such checks are not cashed by the beneficiaries, the U.S. Treasury retains the funds which they represent. As a result, States which have an agreement with the Social Security Administration to include State-funded supplementation of the Federal SSI benefit in the check issued by the U.S. Treasury are precluded from recouping any State funds included in the unnegotiated checks.

EXPLANATION OF PROVISION

Section 343 would limit the negotiability of SSI checks to 180 days from date of issuance. The amount from such unnegotiated checks which represents a State supplementation payment would be returned to the State or credited to the State. The section also would require the Social Security Administration, to the maximum extent feasible, to determine the whereabouts and eligibility of those individuals whose benefit checks were not negotiated within the 180 day limit. It is the intent that the Social Security Administration is to make

every effort to ensure that such individuals are assisted in obtaining the SSI benefits to which they are due.

This provision would be effective October 1, 1981.

d. Special Interim Cost-of-Living Increase in SSI Benefits (Section 344)

PRESENT LAW AND BACKGROUND

Under existing law, a yearly cost-of-living adjustment payable in the SSI checks received in July is made in Federal SSI benefits equal to the percentage adjustment provided for social security retirement and disability insurance beneficiaries. This is done through a reference in the SSI law to the cost-of-living adjustment provisions in Title II of the Social Security Act. Under existing law, the adjustment is based on the change in the Consumer Price Index (CPI) measured from the first calendar quarter of one year to the first calendar quarter of the next year.

The Committee's bill moves the payment of the cost-of-living increase in social security and, by reference in SSI, to October instead of July, after 1982.

To provide for a transition to the new October date for cost-of-living adjustments under social security, the Committee's bill in section 206 provides that an ad hoc increase equal to one-half the increase in the cost-of-living from the first quarter of 1981 to the first quarter of 1982 would be paid in July 1982. In October 1982, a second benefit increase would be computed based on the increase in the CPI from the first quarter of 1981 to the March through May period of 1982 (a 14 month inflation period as compared to the present 12 month period). This increase would be adjusted to reflect the ad hoc increase paid in July, so that the October increase plus the ad hoc increase in July would equal the increase in the CPI over the 14 month measuring period. In this way, beneficiaries would receive a total increase based on 14 months of inflation, from January 1981 to March 1982. Future automatic increases, after 1982, would be based on the CPI change in the March through May period each year, and would be paid in October of each year.

EXPLANATION OF PROVISION

Section 344 would conform the SSI law to the adjustments in cost-of-living in social security that will be made during 1982. In future years, SSI adjustments would continue to be made on the same basis as provided in Title II: they would be based on the CPI change in the period March–May of each year, and would be paid in October of each year.

4. PART D: ENERGY ASSISTANCE TO LOW INCOME HOUSEHOLDS

Program of Assistance (Section 361)

Section 361 amends the Social Security Act by adding a new title—"Title XXI—Energy Assistance to Low Income Households".

The following is a description of the new sections within the proposed new Title XXI of the Social Security Act including a comparison with the current law which expires September 30, 1981.

a. Appropriations Authorized (Section 2101)

PRESENT LAW AND BACKGROUND

Under present law, authority for providing low income energy assistance exists under both section 222(a)(5) of the Economic Opportunity Act of 1964 and the Home Energy Assistance Act of 1980 (Title III of the Crude Oil Windfall Profit Tax of 1980 (P.L. 96-223)). The Economic Opportunity Act does not specify a specific budget authority. The Home Energy Assistance Act authorizes \$3.125 billion for energy assistance in fiscal year 1981. The authority under both Acts will expire on September 30, 1981 unless reauthorized by Congress.

Public Law 96-536, providing for continuing appropriations through June 5, 1981, appropriated \$1.85 billion for low income energy assistance (LIEA) for fiscal year 1981. The funds are appropriated under the authority of the Economic Opportunity Act of 1964. However, the Continuing Resolution provides that LIEA shall be administered under the "terms and conditions" of the regulations and any "non-formula amendments thereto" published May 30, 1980 in the Federal Register pursuant to the Home Energy Assistance Act of 1980. Therefore, references to present law refer to provisions of the Home Energy Assistance Act except for instances in which specific changes were made by the Continuing Resolution.

Under present law, funds appropriated remain available until spent.

EXPLANATION OF PROVISION

The Committee bill would authorize a program of energy assistance for low income households for fiscal year 1982 and fiscal year 1983 by adding a new title to the Social Security Act: Title XXI—Energy Assistance to Low Income Households. The Act would authorize \$1.4 billion for fiscal year 1982 and \$1.6 billion for fiscal year 1983. The Act would require the Secretary of Health and Human Services to make payments to states that submit and have approved state plans for low income energy assistance. Funds appropriated under the Act would remain available until spent.

b. Allotments to States (Section 2102)

PRESENT LAW AND BACKGROUND

Of the \$1.85 billion appropriated for fiscal year 1981 under present law, \$1.776 billion is distributed as formula grants to States; \$20 million is transferred to the Community Services Administration for energy assistance to native Americans and migrants; \$4 million is set aside for Social Security Administration administrative costs; and \$50 million is to be used to meet one of the provisions of the state grant allotment formula related to lessening the impact on certain states

from the changes in the allotment formula. Allotments to States are made on the basis of a complex formula that was specified in Public Law 96-536 providing for continuing appropriations through June 5, 1981.

EXPLANATION OF PROVISION

The Committee bill would distribute 100 percent of the funds appropriated as grants to States. The funds would be allotted on the basis of States' allotment percentages. The allotment percentages would be defined as the shares of federal funds States are receiving under the formula provisions of the fiscal year 1981 program. This would include the provisions of the Continuing Resolution and its references to the Home Energy Assistance Act and fiscal year 1980 payments.

Under the Committee bill, the Secretary would be authorized to reallocate funds he determines will not be used by a State in a fiscal year. However, a State could request that up to 25 percent of its allotment for any fiscal year be held available for its use during the following fiscal year. The base used to determine the maximum a State may carry over would consist only of funds allotted to it during the current fiscal year, and would not include funds held over from any previous fiscal year. In order to reallocate, the Secretary would have to do the following: notify the chief executive officer of a state of the intent to reallocate a portion of its funds, publish notice in the Federal Register of the intent to reallocate, and receive comments for a 30-day period following publication of the notice. Any funds to be reallocated after this 30-day period would be treated as part of the funds available for allotment for the following fiscal year (to be distributed according to the State allotment percentages).

Similar to current law, the Secretary would be authorized to make payments directly to Indian tribal organizations if he determines that members of an Indian tribe would be better served through such direct grants. The allocation of the State in which the tribe resides would be reduced by the amount of any such direct grant.

As under present law, the Secretary could reserve, at the State's request, a portion of a State's allotment to make direct payment to qualified recipients of Supplemental Security Income (SSI).

There would be no federal limit on the maximum yearly benefit paid to households, in contrast to the fiscal year 1981 program. The Committee believes that the State should have flexibility in determining such limits as it believes appropriate, taking into account public comments received by the State on its proposed State plan.

c. State Plans (Section 2103)

PRESENT LAW AND BACKGROUND

Under present law, to receive a low income energy grant, a State must submit and have approved by the Secretary a plan which meets specified federal requirements. These plans must describe the program the State intends to operate, and demonstrate that assistance will be available through payments to home energy suppliers, eligible households in certain cases, combinations of supplies and households, and building operators in subsidized housing projects. Although benefit

levels may vary according to such factors as type of fuel, household size or region, benefits must be scaled so they are highest for households with the greatest home energy costs in relation to income. Priority must be given to households with lowest income or with an elderly or handicapped member.

EXPLANATION OF PROVISION

As under current law, the Committee bill would require States to submit a plan for approval to the Secretary before receiving low-income energy grants. In recognition that energy related circumstances vary substantially among the States, the bill allows the States greater flexibility and discretion in the design and operation of their low-income energy assistance programs than allowed under current law. It is the clear intent of the Committee that any Federal regulations, requirements or restrictions promulgated in relation to the State plan requirements or any other provisions contained in this bill not undermine the ability of the States, or limit the flexibility necessary for each State, to design a program that (1) meets the particular needs of the State; (2) utilizes the most appropriate and effective administrative agencies and resources available to the State; and (3) allows for the timely and efficient payment of energy assistance to those in need.

Under the Committee bill, the State plan must provide for a State program for furnishing assistance in meeting home energy costs of households through payments to one or more of the following: (1) eligible households who need assistance to pay for the cost of heating; (2) eligible households who need assistance to pay for the cost of cooling; (3) home energy suppliers under agreements developed by the state; and (4) building operators in assisted housing projects.

In addition, the Committee bill would allow States the option of using federal low income energy assistance funds to purchase, provide and install conservation/weatherization materials. This would include the provision of devices to utilize renewable resources; and making improvements in heating or cooling systems designed to improve heating or cooling efficiency. Under the Committee bill, States would be responsible for determining what materials, devices and improvements would be provided. For example, States could include furnace retrofitting among the means to improve the efficiency of the heating system. Such weatherization/conservation activities could be conducted not only in single family dwellings but also in multi-family dwellings where a substantial number of households eligible under the State plan may live. The Committee bill would further provide greater flexibility by allowing States to meet energy-related emergency needs of eligible households, including in-kind assistance, without the three percent restriction in current law.

To the extent that it would not interfere with the efficient and timely payment of benefits, States would be required to provide the highest level of assistance to households with the lowest incomes and the highest energy costs in relation to income.

The Committee bill would require States to designate in their plans a State agency to administer the program, describe administrative

arrangements for carrying out the program, assure equitable treatment of renters and owners, provide for public participation in the development of the plan, provide an opportunity for a fair hearing to anyone denied assistance or not served promptly, provide for coordination with related energy programs, and provide for appropriate and necessary outreach. States would also be required to establish procedures for monitoring assistance provided under the plan, including the monitoring and auditing of agreements entered into with home energy suppliers, and to establish fiscal control and fund accounting procedures to ensure proper use and accounting of federal funds. The Committee bill would further require States to submit whatever reports the Secretary may reasonably require with respect to the plan. However, the Committee expects the Secretary to request only information directly related to the plan which is necessary to ensure compliance with the plan and with the program's goals.

Any state plan meeting the above requirements would be approved by HHS. The Secretary could waive any requirement if such a waiver would enhance the ability of a State to design and operate a program that meets the particular needs of the State and allows for the timely and efficient payment of assistance. Before disapproving a plan, the Secretary would be required to give the State notice and opportunity for a hearing, as in present law.

d. Low Income Energy Grants to States (Section 2104)

PRESENT LAW AND BACKGROUND

Under present law, LIEA is 100 percent federally funded, except that States must pay 50 percent of administrative costs. The Federal Government sets maximum eligibility criteria. However, States may set eligibility standards at lower levels than the federal maximum. To be eligible for LIEA benefits households must have at least one individual who is "categorically eligible" or have a household income at or below the Bureau of Labor Statistics' lower living level. The one exception is that single person households may have incomes below either the lower living level or 125 percent of the poverty level. A categorically eligible individual is a person who is eligible for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Food Stamps, or certain veterans benefits. However, households eligible solely on the basis of eligibility for SSI are not eligible for benefits if the SSI recipient is in an institution receiving Medicaid, is a member of a shared household resulting in reduced SSI benefits (one-third reduction), or a child recipient of SSI living at home. In determining household income, States are required to use the procedure used in their AFDC program.

EXPLANATION OF PROVISION

The Committee bill would reimburse States for 100 percent of their expenditures, including administrative costs, incurred carrying out their State energy assistance plan in fiscal year 1982. The Federal government would pay 80 percent of these expenditures in fiscal year 1983.

No Federal payments could be made for assistance to a household unless the household has either at least one individual eligible for AFDC, SSI, Food Stamps, or certain veteran's benefits, or the household's income is below 150 percent of the poverty line or, at the option of the State, 60 percent of the State's median income (adjusted for family size). A State could establish a lower income eligibility level. The exclusion of certain SSI recipients, including those residing in certain institutions, would be continued. For determining household income, States could use the procedure they use in their AFDC program or other income assistance or service program.

c. Definitions (Section 2105)

PRESENT LAW AND BACKGROUND

Current law defines a household as any individual or group of individuals who are living together as one economic unit for whom residential energy is customarily purchased in common or who make undesignated payments for energy in the form of rent. Current law also defines home energy as a source of heating or cooling in residential dwellings. A definition of the Bureau of Labor Statistics' lower living standard income level, which is the income eligibility guideline used in the current program, is included in current law. Finally, current law defines State to include only the 50 States and District of Columbia. The outlying areas receive grants through a special set-aside.

EXPLANATION OF PROVISION

The Committee bill would define a household as all individuals who occupy a housing unit. The Committee bill would rely on the concept of a housing unit used by the Census Bureau. In general, one or more rooms occupied as separate living quarters would be considered a housing unit for purposes of the program. The Committee does not intend energy assistance to be available to institutions or military barracks, which would be excluded under the Census Bureau definition. The Committee, however, wishes to emphasize that it does intend that States be allowed to provide assistance to boarding homes and group homes whose residents meet other eligibility requirements.

The Committee bill, like the current law, would define home energy as a source of heating or cooling in residential dwellings. Definitions of the poverty level and State median income also would be included since a percentage of these standards would be used as the cutoff points for assistance. Poverty level would be defined in the Committee bill as the nonfarm poverty guidelines developed by the Office of Management and Budget. State median income would be defined as the State median incomes published by the Department of Health and Human Services (HHS) for use in Title XX of the Special Security Act, adjusted for household size. Further, the Committee bill, which would allocate funds to the outlying areas in the same way as States, would define "State" to include the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands, in addition to the 50 States and District of Columbia.

f. Administration (Section 2106)

PRESENT LAW AND BACKGROUND

Current law requires the Secretary to publish regulations for the low-income energy program within 60 days of the law's enactment. The Secretary may delegate all functions, except the making of regulations, to any HHS officer or employee, and may use the services and facilities of other Federal or public agencies to administer the program. The current law also provides that assistance provided through the low-income energy program shall not be considered income or resources for any purpose under any other Federal or State law, and also amends the Food Stamp Act so that increases in State public assistance grants intended primarily to offset the costs of energy will not be considered income during fiscal year 1981 in the Food Stamp program.

EXPLANATION OF PROVISION

The Committee bill would require the Secretary of HHS to publish regulations within 60 days of the program's enactment, and would authorize the Secretary to delegate functions, except rule-making, to other HHS employees and officers. HHS would be authorized to use the services and facilities of other Federal or public agencies and would be required to set up procedures for Federal monitoring of State administration. The Secretary would be required to coordinate the program with related activities under the Economic Opportunity Act or other similar programs. The Committee bill would also provide that assistance provided to a household under this program would not be considered income or resources under other Federal or State laws. Further, payments would be authorized to States in installments in advance or by reimbursement, with necessary adjustments for overpayment or underpayments as in present law.

5. PART E: SOCIAL SERVICES

Limitation on Aggregate Title XX Training Expenditures in 1982 (Section 381)

PRESENT LAW AND BACKGROUND

Under current law, 75 percent Federal matching funds are available to States for training costs related to the Title XX social services program. These funds are in addition to matching funds provided under the Title XX social services program statutory ceiling. Beginning in fiscal year 1982 States are to be reimbursed only for those expenditures included in a State training plan approved by the Department of Health and Human Services. Under Title XX law, funding for training programs is on an open-ended entitlement basis. However, a limit of \$75 million was placed on the appropriation for fiscal year 1981.

EXPLANATION OF PROVISION

Section 381 would continue through fiscal year 1982 the \$75 million limitation on Federal Title XX funds that was in effect in fiscal year

1981. Each State will be allotted the same share of the \$75 million in fiscal year 1982 as it was allotted in fiscal year 1981.

D. TITLE IV: MEDICARE AMENDMENTS

1. PART A: CHANGES IN BENEFITS

a. Elimination of Part A Coverage of Alcohol Detoxification Facility Services (Section 401)

PRESENT LAW AND BACKGROUND

Under Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, effective April 1, 1981, qualifying freestanding alcohol detoxification facilities are recognized as providers under medicare. As with hospitals, these facilities are reimbursed by medicare part A on a reasonable cost basis. In conjunction with the extension of coverage to freestanding alcohol detoxification facilities, Congress instructed the Secretary to undertake studies and demonstration projects on alcoholism rehabilitation, drug detoxification, and incentives for the use of lower cost freestanding detoxification facilities.

EXPLANATION OF PROVISION

The bill would repeal the existing medicare provision under which reimbursement for inpatient services in freestanding alcohol detoxification facilities is authorized. In addition, the bill provides for the cancellation of a number of studies and demonstration projects whose purpose was to evaluate the new coverage and its potential for expansion.

Repeal of this provision does not constitute repeal of coverage under medicare for inpatient detoxification services. These services have long been, and will continue to be, covered when provided by a participating hospital. The Committee felt that repeal of coverage for freestanding detoxification facilities eliminated the need for the proposed studies and demonstration projects.

This section is effective with respect to inpatient stays in detoxification facilities beginning on or after the tenth day after the date of enactment.

b. Nutritional Therapy Under the End Stage Renal Disease Program (Section 402)

PRESENT LAW AND BACKGROUND

Present medicare law provides no coverage for nutritional therapy for the treatment of end stage renal disease (ESRD).

EXPLANATION OF PROVISION

The bill would provide coverage under the medicare program for nutritional therapy, when it is used as a means of delaying, or sub-

stituting for, the provision of kidney dialysis, for those beneficiaries who would otherwise qualify for medicare benefits.

Nutritional therapy may, in general, be defined as the use of specifically manufactured foods that are of "high biologic value." These foods may help individuals with end stage renal disease to maintain an appropriate level of protein in their diet, while at the same time providing certain essential amino acids and sufficient calories to maintain nitrogen balance.

There is limited evidence that nutritional therapy may delay the necessity for renal dialysis or may result in a reduction in the number of renal dialysis treatments required. The Committee is aware that the use of nutritional therapy in the treatment of end stage renal disease is a new approach and, therefore, expects the Secretary to implement this provision in a manner which will ensure that payment will be made under this provision only where there is evidence that nutritional therapy is both medically necessary and cost-effective.

The Committee is concerned that little data is available regarding the costs of nutritional therapy supplies and other costs associated with nutritional therapy, and that nutritional therapy as a treatment modality is in the process of development and change. The Committee expects the Secretary of Health and Human Services (HHS), in consultation with experts in the fields of nephrology and nutrition (especially nutritional therapy) and with suppliers of nutritional therapy supplies, to establish regulations and guidelines for the coverage of, and reimbursement for, nutritional therapy supplies and related physician and other services.

Under current law, entitlement to benefits under part A of medicare and eligibility to enroll under part B begins with the third month after the month in which a regular course of renal dialysis is initiated. (In addition, eligibility can be established by reason of kidney transplantation.) The bill would provide entitlement to benefits beginning with the earlier of the third month after the month in which a regular course of renal dialysis is initiated or the third month after the month in which a regular course of renal dialysis would have been initiated but was not initiated because nutritional therapy was provided. The Committee recognizes the difficulty in fixing a precise date on which renal dialysis would have begun, but expects the Secretary to establish guidelines and regulations to ensure that only those patients with end stage renal disease became eligible for medicare benefits under this provision.

The enactment of this provision shall not be construed as releasing the Secretary from his obligation, under Public Law 96-499, to study and conduct a demonstration project and submit legislative recommendations to the Congress by December 5, 1982, concerning the effectiveness of nutritional therapy in early renal failure in retarding or arresting the progression of the disease with a resultant deferment of dialysis.

The effective date of the section specifies that no person can establish entitlement to benefits under this provision on the basis of nutritional therapy furnished before October 1, 1981.

2. PART B: CHANGES IN COINSURANCE, DEDUCTIBLES, AND PREMIUM

a. \$1 Copayment for Each of First 60 Days in Hospital (Section 411)

PRESENT LAW AND BACKGROUND

Present law imposes no copayment on medicare beneficiaries for the first 60 days of inpatient hospital services. Under current law, there is an inpatient hospital deductible roughly equivalent to the cost of one day of hospital care during each spell of illness. In addition, under present law, beneficiaries are responsible for a daily coinsurance amount, beginning with the 61st day of hospitalization, equal to one-fourth of the inpatient hospital deductible.

EXPLANATION OF PROVISION

The bill would make medicare inpatients subject to a \$1 copayment for each of the first 60 days of care during a spell of illness.

The Committee has adopted the \$1 per day copayment as a means of achieving a necessary reduction in medicare program costs in a way that is not unduly burdensome to individual beneficiaries.

This section is effective with respect to inpatient hospital services furnished on or after October 1, 1981.

b. Making Part A Coinsurance Current With the Year in Which Services are Furnished (Section 412)

PRESENT LAW AND BACKGROUND

Under present law, the part A coinsurance is determined as a fraction of the deductible in effect for the year in which a spell of illness begins. Thus, for the beneficiary who experiences a spell of illness that overlaps 2 or more calendar years, no adjustment is made in the part A coinsurance to reflect any change in the deductible.

EXPLANATION OF PROVISION

Under the bill, part A coinsurance will be based on the current year's deductible, rather than the deductible in effect at the time the beneficiary's spell of illness began.

The bill's requirement that part A coinsurance be based on the current year deductible will not only reduce medicare program costs but will also simplify administration by making part A coinsurance amounts the same for all beneficiaries regardless of when their spell of illness began.

This amendment is effective with respect to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1982.

c. Making the Part A Deductible and Coinsurance More Current (Section 413)

PRESENT LAW AND BACKGROUND

Under present law, a beneficiary is required to meet a deductible in each spell of illness before medicare payment for inpatient hospital care begins. Medicare also deducts from its payment for hospital stays that extend beyond 60 days and extended care stays that extend beyond 20 days coinsurance amounts that are calculated as a fraction of the inpatient deductible. In concept, the inpatient deductible increases each year to reflect the cost of one day's hospital care, but in practice the calculation lags about 2 years behind actual hospital cost increases.

EXPLANATION OF PROVISION

The bill would make the part A deductible and coinsurance amounts more current.

The Committee believes that the necessity of achieving a reduction in medicare program costs warrants making the deductible more reflective of the cost of 1 day's hospital care. This would be accomplished by adding \$5 to the base figure of \$40 in the formula that is used in the determination of the inpatient hospital deductible.

This section would become effective for inpatient hospital services and post-hospital extended care services furnished in calendar years beginning with 1982.

d. Elimination of Carryover From Previous Year of Incurred Expenses for Meeting the Part B Deductible (Section 414)

PRESENT LAW AND BACKGROUND

Under present law, the annual part B deductible for any year will be reduced by the amount of any covered expenses which the individual incurs in the last 3 months of the preceding calendar year even if these expenses were applied toward the deductible in the preceding year.

EXPLANATION OF PROVISION

The bill would repeal the provision of present law that permits medicare beneficiaries to count expenses incurred in the last quarter of the previous calendar year in determining whether they have met the annual part B deductible for the new year.

In the Committee's judgment, elimination of the part B deductible carryover provision is appropriate at a time when there is general agreement that steps must be taken to restrain the rising cost of the medicare program.

This section would become effective with respect to the deductible for calendar year 1982.

e. Increase In, and Indexing of, Part B Deductible (Section 415)

PRESENT LAW AND BACKGROUND

Under present law, medicare part B beneficiaries are subject to a \$60 annual deductible and are thus responsible for the first \$60 of the cost of covered services (with certain exceptions).

EXPLANATION OF PROVISION

The bill amends present law to increase the annual part B deductible from \$60 to \$70, and, beginning in 1983, to index the deductible so that it increases each year by the same percentage as the annual cost-of-living increase in monthly social security cash benefits.

Each year, beginning in 1982, the Secretary will announce the amount of the part B deductible for the next calendar year. The deductible will be rounded to the nearest multiple of \$1. The Secretary's announcement will be made at the time the annual cost-of-living increase in monthly social security benefits is announced. The deductible increase announced will reflect the percentage increase in social security benefits in that year and will become effective on January 1 of the following year.

Despite the upward spiral of health care costs, no change has been made in the deductible since 1973. The Committee's decision to increase and subsequently index the part B deductible reflects its desire to restrain increases in the cost of the program without eliminating benefits or imposing unreasonable burdens on beneficiaries. Indexing the part B deductible makes its treatment consistent with the annual adjustment of the part A deductible and coinsurance, and the annual increase in the part B premium provided for under present law.

The increase in the deductible to \$70 will become effective for expenses incurred during calendar year 1982. The indexing of the deductible will be effective for expenses incurred during calendar year 1983 and later years.

f. Changes to Part B Premium to Conform to Title II Changes (Section 416)

PRESENT LAW AND BACKGROUND

Under present law, persons age 65 and over may enroll in part B of medicare for coverage of physician and other services by paying a monthly premium. The premium is increased each July. (The present monthly premium is \$9.60 and is scheduled to rise to \$11 on July 1, 1981.) The maximum percentage by which the part B premium is permitted to increase each July is the percentage by which the monthly social security benefits have increased over the year.

The medicare part B premium is withheld from the monthly check of a social security beneficiary. The annual cost-of-living increase in monthly benefits is reflected in the benefit check received at the beginning of July, and the annual medicare part B premium increase is reflected in increased withholding from the same benefit check.

People aged 65 and over who are not entitled to monthly social security benefits may obtain medicare part A hospital insurance protection by enrolling and paying premiums based on the actuarial value of part A protection. To obtain part A protection, such persons must also be enrolled in medicare part B.

Present law requires the Secretary, during December of each year, to determine and announce the monthly medicare part B premium amount that will be in effect for the 12-month period commencing July 1 of the succeeding year. (A similar announcement regarding part A premiums is required during the last calendar quarter of each year.) In the past, a December announcement was necessary to assure that people considering whether to enroll in medicare during the annual January through March open enrollment period would be apprised of what their premium amounts would be the following July when their coverage began. However, recent legislation (Public Law 96-499) has eliminated the annual open enrollment period, providing instead for continuous open enrollment.

EXPLANATION OF PROVISION

Under the bill, medicare part B premiums (and Federal general revenue contributions toward the cost of part B) would be increased each year on October 1, rather than July 1. A corresponding change would be made with respect to part A premiums payable by eligible uninsured persons who purchase protection under medicare part A. These changes are made to conform with a change the bill makes in the date of the annual cost-of-living adjustment in monthly social security benefits payable under title II of the Social Security Act, in order to preserve the relationship between the timing of the annual increases in monthly benefits and the annual increases in medicare part B premiums.

Although the bill provides for an ad hoc increase in monthly social security benefits to be reflected in the benefit check received in July 1982 and for a subsequent increase reflected in the October 1982 check, the bill does not provide for an interim increase in medicare premiums. Instead, the medicare premium amounts and government contribution level applicable for the 12 months beginning July 1, 1981, will remain in effect through September 1982, and the permanent change to an October 1 premium increase date will occur on October 1, 1982. The October 1, 1982 premium increase will reflect the full amount of the increase in October plus the ad hoc increase in July.

The bill retains the requirement that the part B premium will increase by no more than the benefit increase percentage. Under the bill, the premium increase in each October may not exceed the monthly cost-of-living increase percentage that will be effective for September of that year and will be reflected in the October check. The amount of the premium that will be payable for the 12-month period beginning October 1 of each year will be announced by the Secretary before July 15 of that year. This announcement schedule will permit the Secretary to announce medicare premium amounts at the same time as the annual cost-of-living increases in monthly social security benefits are announced.

3. PART C: CHANGES IN REIMBURSEMENT

a. Offset of Interest and Other Income on Funded Depreciation (Section 421)

PRESENT LAW AND BACKGROUND

Medicare reimburses providers for necessary and proper interest on current and capital indebtedness. In general, interest and other investment income must be used to offset allowable interest expense for which a provider may be reimbursed. Current regulation exempts income earned on funded depreciation accounts.

Providers may set aside cash or other liquid assets in a separate fund, known as a funded depreciation account, which may be used for the replacement of assets or for other capital purposes. The provider usually deposits in such accounts monies equal to the amount of annual depreciation expense charged to costs. The Secretary through regulation and policy, and the Provider Reimbursement Review Board through its decisions have established which funds are considered funded depreciation.

The exemption of interest on funded depreciation from the offset of interest income was originally intended as an incentive for hospitals to set aside funds for the replacement of assets. It was believed that this would reduce the need for hospitals to borrow funds for which Medicare would be required to reimburse interest expense. In practice, however, some providers have used such funds for capital expansion purposes other than those originally intended. Rather than using the funds for replacement of worn out assets, some hospitals have used the funds as sinking funds for the financing of hospital bond issues. Often, where sinking or reserve funds are required by the terms of a bond indenture, providers have used funded depreciation accounts for such purposes rather than those for which the account was established, thereby requiring the hospital to incur additional indebtedness for the replacement of assets.

EXPLANATION OF PROVISION

Under the bill, interest and other income earned on funded depreciation would be offset against allowable interest expense. The provision would be effective with respect to interest and other income earned on or after October 1, 1981.

b. Elimination of Occupancy Test for Hospital Long-term Care in Nonpublic Hospitals (Section 422)

PRESENT LAW AND BACKGROUND

Present law, as amended by Public Law 96-499, provides that, where a beneficiary who no longer requires acute hospital services must remain in the hospital because no long-term care bed is available in the area, the hospital will be reimbursed at a daily rate equal to the adjusted average Medicaid skilled nursing facility (SNF) rate in the State for persons needing SNF services, and for purposes of Medicaid, at the intermediate care facility (ICF) rate for patients needing ICF

services. The reduced level of reimbursement does not apply where a hospital's annual occupancy rate is equal to or greater than 80 percent.

EXPLANATION OF PROVISION

The bill generally eliminates the special treatment of hospitals meeting the occupancy test thus, a hospital's occupancy rate would no longer be a factor in determining whether reimbursement is to be made at the reduced rate.

The bill makes an exception with respect to hospitals (generally, public hospitals), that derive less than 30 percent of their total income from nongovernmental sources; thus, for public hospitals, which serve as hospitals of last resort for the poor and many of which are financially distressed, the 80 percent occupancy test would be retained. In addition, the Committee bill specifies that the reduction in reimbursement would not be imposed with respect to any hospital if the Secretary determines that there is no excess of hospital beds in the area in which the hospital is located.

Elimination of the occupancy test reflects the Committee's view that, in a period when hospital costs are continuing to rise dramatically and numerous long-term care patients inappropriately remain in acute care hospital beds, it is appropriate to provide additional incentives for the establishment of needed long-term care beds, and especially for the conversion of acute care beds to long-term care beds. Where there is no excess of acute care beds in an area, however, the Committee believes it appropriate not to impose reduced reimbursement under the provision for hospitals in that area.

The Committee recognizes that in certain instances repeal of the 80-percent occupancy rate exemption will cause undue hardship. In order to alleviate such hardship, the Committee intends that the Secretary shall not penalize any hospital which has an annual occupancy rate of 80 percent or above and which can demonstrate to his satisfaction that in the hospital's own service area there does not exist in that area an excess of acute hospital beds which could accommodate long-term care (and SNF) patients.

The section is effective with respect to services provided by a hospital beginning with the month after the date of enactment.

c. Incentive Reimbursement Rate for Renal Dialysis Services (Section 423)

PRESENT LAW AND BACKGROUND

Amendments to the Social Security Act made in 1978, Public Law 95-292, were designed to accomplish several objectives including, among others, providing incentives for the use of lower cost, medically appropriate self dialysis (particularly home dialysis), as an alternative to higher cost institutional dialysis. With respect to the objective of increasing the use of lower cost medically appropriate home dialysis, the Committee notes that since enactment of the amendments of 1978 there has been a modest increase in the number of end stage renal disease (ESRD) patients self-dialyzing at home. Con-

sidering the rapid decline in home dialysis utilization during the initial 5 years of the program, this recent reversal of that decline is encouraging.

However, given the continuing escalation in both the population of ESRD patients and program costs and given current estimates that a substantially greater number of renal patients could be dialyzed in the home setting, the Committee believes that there is a need for increased efforts to stimulate greater growth in the percentage of patients dialyzing in the home. While the Committee recognizes that not all patients are medically appropriate candidates for home dialysis and some local variances in the proportion of home patients is understandable, there is concern that in most localities only a very small percentage of ESRD patients are dialyzing at home.

Public Law 95-292 authorized the use of an incentive reimbursement system with respect to payment for dialysis services provided to patients treated in facility settings. While no incentive method has yet been implemented, the Secretary has a proposal under consideration which would establish a single reimbursement rate for renal dialysis services provided in hospitals and free-standing facilities. This single facility reimbursement rate would be computed based on the cost experience of the more efficient facilities.

The Committee is concerned, however, that the provision of a single rate approach for facility services only (that is, not including home dialysis services) may have a negative impact on the Committee's stated objective of encouraging lower cost home dialysis. In effect, as the facility rate becomes more restrictive, the Committee is concerned that facilities are likely to limit home efforts in order to increase their facility patient population, retaining in the facility setting those stabilized patients who might otherwise be referred to home dialysis, in order to make up in volume for any reductions in the payment rate.

EXPLANATION OF PROVISION

The bill requires the Secretary of Health and Human Services to prescribe in regulations a method (or methods) for determining the amounts of payments to be made for renal dialysis services, incorporating in a single reimbursement rate structure, reimbursement for dialysis treatments in a facility and dialysis treatments in the home setting. The method promulgated by the Secretary would provide for a prospectively set rate (or rates) for each mode of care, and would be established on the basis of a single composite weighted formula taking into account the proportions of an institution's patients dialyzing in the facility and those dialyzing at home. If the Secretary, after detailed analysis, determines that an alternative rate setting method would provide greater incentives for increased use of lower cost home dialysis than would a single composite rate, such an alternative rate setting method may be promulgated. The Committee intends that the new method of payment for dialysis services may be used in lieu of present law provisions concerning target reimbursement for home dialysis services.

Because of its concern over the potential impact of the single facility rate, the Committee's bill would require the Secretary to examine an

alternative method which would incorporate reimbursement for facility dialysis and home dialysis in one rate; that is, a *single composite rate*. The Committee expects the Secretary to consider the composite rate before any final regulations implementing any other changes in the renal dialysis reimbursement rate are promulgated. A composite rate could be developed by using the average costs of outpatient facility dialysis (based on the experience of more cost efficient facilities) and the average costs of home dialysis and applying different weights for each mode of care. Since the Secretary has been reimbursing under the medicare program for home dialysis services since 1973, adequate cost data should be available on which to establish costs for the home dialysis component of the composite rate. The weight factors applied could be related to the national proportion of patients treated in the facility and home settings as of the end of the most recent reporting year prior to implementation of a composite rate system. If, for example, the national patient distribution at the time of implementation was 85 percent in facility settings and 15 percent in the home setting, the outpatient facility component and home dialysis component could be given weights of 85 and 15 percent respectively. Thus, for illustrative purposes only, if it is assumed that the average cost for outpatient facility dialysis is \$130 and home costs are \$90, the basic formula for determining the applicable composite rate could be as follows:

$$\begin{array}{r} \$130 \times .85 = \$110.50 \\ + \$90 \times .15 = \quad 13.50 \\ \hline \text{Composite rate} = \$124.00 \\ \hline \hline \end{array}$$

Under this approach, facilities will have not only an incentive to maximize the cost efficiency of their facility dialysis services but also to refer patients who are appropriate candidates for home dialysis to self care training and subsequent treatment in the home setting.

To preclude unreasonable profits for facilities with home populations substantially in excess of the national average, while at the same time rewarding them for their performance in supporting less costly care, the basic formula could be modified. For example, the formula could be modified to use 95 percent of such facility's most recent home patient population percentage, in lieu of the national home patient average, in determining the home dialysis weighting factor. If, for example, a facility has 30 percent of its patient population on home dialysis, the modified formula for determining the composite rate could be as follows:

$$\begin{array}{r} 95\% \text{ of } 30\% = .285 \\ \$130 \times .715 = \$92.95 \\ + \$90 \times .285 = \quad 25.65 \\ \hline \text{Modified Composite Rate} = \$118.60 \\ \hline \hline \end{array}$$

In this manner, potential profits for facilities performing above the national average with respect to placement in less costly home dialysis would be kept reasonable, but there would be a continuing incentive to refer suitable patients to home care.

Under a composite rate approach, facilities treating a maintenance dialysis population would be provided an incentive to offer home dialysis services. The composite rate should be adjusted periodically to account for changes in the average costs and changes in the relative weights attributable to each mode of care as the proportion of home dialysis patients rises. The composite rate would be payable to all facilities for all patients whether dialyzing in the facility or at home. However, it is the Committee's intent that an exception procedure would be applicable to accommodate the added costs of facilities, usually hospitals, whose dialysis services are largely geared to less stabilized, more costly patients, such as pediatric patients, pre- and post-transplant patients and those with other complicating conditions.

In determining the average costs for the home component of the composite rate, the Committee expects that the Secretary would take into consideration the average equipment and medical supply costs of home care and the average costs of providing appropriate support services to home patients. Support services include, but are not limited to, services by medical and nonmedical personnel who must be available to assist home patients with medical and social services and to provide technical support such as equipment maintenance and repair. Additionally, the Committee expects that, under a composite rate approach, all facilities would be required to assume responsibility for arranging for all necessary equipment and supplies, reimbursing suppliers providing these services and billing other supplementary third party insurers. These responsibilities will understandably generate added administrative costs for facilities, especially with respect to handling the collection of coinsurance from supplemental insurers, a function that, under current reimbursement practices, is often handled by individual suppliers of equipment and supplies. However, it is anticipated that, if a composite single rate reimbursement methodology were implemented, billing and collection of copay amounts from supplemental insurers would be simplified.

The Committee recognizes that some patients who are appropriate candidates for self-dialysis in the home may be precluded from treatment in that setting because of the absence of a family member or other individual to assist them with dialysis. This is particularly true with hemodialysis treatment as opposed to other treatment techniques, such as continuous ambulatory peritoneal dialysis (CAPD). While provision for the costs of providing for paid assistants for home patients would permit these patients to dialyze in the home setting, the increased labor costs that would result would virtually eliminate the relative cost effectiveness of home treatment. Although facilities would not be precluded from providing paid assistants to patients who require such services, under the composite single rate approach, a separate allowance for such costs in the home component of the composite rate would not be authorized.

The Committee believes the composite rate approach is one that may most effectively accomplish these objectives by encouraging all facilities to pursue the goal of increasing self care, particularly home dialysis. The determination as to where patients are treated, that is, facility, facility self-care, or home, and the type of treatment provided, such as hemodialysis, standard peritoneal or continuous ambulatory peri-

toneal dialysis remains the prerogative of the attending physician. No specific home dialysis goals are mandated but the reimbursement incentive should encourage the selection of the least costly medically appropriate form of treatment for each patient.

In addition, in a further effort to eliminate any remaining disincentives for home dialysis, the Secretary would be expected to consider some liberalization of reimbursement for home training expenses incurred by the patient and family member who will assist him or her with home dialysis.

This provision would apply to services furnished on or after October 1, 1981.

d. Limits on Reimbursement to Home Health Agencies (Section 424)

PRESENT LAW AND BACKGROUND

Present law authorizes the Secretary of HHS, in determining the reasonable costs of services furnished to medicare patients, to exclude costs estimated to be unnecessary in the efficient delivery of needed health services. In implementing this authority with respect to home health services, the Secretary has established a schedule of reimbursement limits for home health agencies which is updated periodically. The limits are expressed in terms of costs per visit, and although they are established by type of service (e.g., skilled nursing, home health aide), they are applied to each home health agency as a single aggregate limit, based on the agency's number of visits for each type of service. Currently, the limits under this methodology are set at the 80th percentile.

EXPLANATION OF PROVISION

The bill would reduce from the 80th to the 75th percentile the medicare reimbursement limits currently applied to home health agency costs, thus establishing a more stringent criterion for determining whether costs are excessive. In view of the need for cost constraint, the Committee believes these tighter limits are an appropriate means of encouraging efficient operation of home health agencies.

The Committee does not intend to preclude the Secretary from modifying in the future the methodology for establishing home health reimbursement limits and recognizes that, under a modified approach, it may no longer be appropriate to set the limits at the 75th percentile. For example, a limit determined in relation to the mean of per visit costs may in the future be found to be appropriate. Accordingly, the bill specifies that the limit is to be either at the 75th percentile or such lower percentile or such comparable or lower limit as the Secretary may determine. Whatever methodology is used, however, the intention is that the limits be set at a level no less stringent than what is represented by the 75th percentile under the current methodology.

Under a classification system used for determining and applying the current home health reimbursement limits, there are separate limits for provider-based (primarily hospital-based) home health

agencies and for freestanding home health agencies. The limits for hospital-based agencies are significantly higher than those for freestanding agencies. Freestanding agencies have questioned the fairness of the separate category for hospital-based agencies, claiming that the separate limits discriminate against them and put them at a competitive disadvantage. Some have also suggested that subjecting provider-based home health agencies to the lower limits applicable to freestanding agencies would offer an opportunity for reduction in medicare program costs.

On the other hand, the justification given for the current use of separate limits is that they are necessary to avoid unjust reimbursement penalties resulting from medicare's hospital cost allocation requirements. These requirements force hospital-based home health agencies to include in their cost reports a share of the costs from the hospital's overhead accounts that is not directly commensurate with the costs incurred by freestanding agencies.

The Committee is concerned about the apparent anomaly of separate limits for hospital-based and freestanding home health agencies, despite the fact that both render similar services. Accordingly, the Committee expects the Secretary to make a comprehensive reassessment of the continued need for separate limits, of the prospects for revising medicare hospital cost-allocation procedures, and of other possible changes in response to concerns arising from the existence of separate limits. The Committee requests that the Secretary report to the Congress no later than January 1, 1982, on the findings of this study, and include in the report any planned or proposed changes relating to the issue of separate limits and the timetable for their implementation.

The provision of the bill is effective with respect to cost reporting periods of home health agencies ending after September 30, 1981, but the lower limits would be applied in proportion to that part of the agency's cost accounting period occurring after that date.

e. Limits on Reimbursement to Hospitals (Section 425)

PRESENT LAW AND BACKGROUND

Present law authorizes the Secretary of HHS, in determining the reasonable costs of services furnished to medicare patients, to exclude costs estimated to be unnecessary in the efficient delivery of needed health services. In implementing this authority with respect to inpatient hospital services, the Secretary has established a schedule of reimbursement limits on hospital inpatient general routine operating costs which is updated periodically.

The limits under the methodology currently in use are on a per diem basis and are set at 112 percent of the mean labor-related, and of the mean non-labor-related costs of each comparison group of hospitals.

EXPLANATION OF PROVISION

The bill would reduce from 112 to 108 percent of the mean the medicare reimbursement limits currently applied to hospital inpatient general routine operating costs, thus establishing a more stringent cri-

terion for determining whether costs are excessive. In view of the need for cost constraint the Committee believes these tighter limits are an appropriate means of encouraging efficient operation of hospitals.

In recent years, a series of modifications in the methodology for determining hospital reimbursement limits has been implemented, to make more accurate and equitable the system for estimating costs in excess of those necessary in the efficient delivery of needed health services. The Committee does not intend to preclude the Secretary from further refining the methodology in the future, or from expanding it, for example, to encompass ancillary costs of hospitals. The Committee recognizes that under such a modified approach it may no longer be appropriate to set the limits at 108 percent of the mean. Accordingly, the bill specifies that the limit is to be either at 108 percent of the mean or such lower percentage or such comparable or lower limit as the Secretary may determine. Whatever methodology is used, however, the intention is that the limits be set at a level no less stringent than what is represented by 108 percent of the mean under the current methodology.

The section is effective with respect to cost reporting periods of hospitals ending after September 30, 1981, but the lower limits would be imposed only in proportion to that part of the hospital's cost reporting period occurring after that date.

4. PART D: MISCELLANEOUS CHANGES

a. Civil Money Penalties (Section 431)

PRESENT LAW AND BACKGROUND

Under present law, the Secretary of Health and Human Services has no independent authority to impose monetary penalties for fraudulent claims under the medicare or medicaid programs. Currently, the Secretary's authority is limited to barring practitioners or providers from participation or referring cases of criminal fraud to the Department of Justice for prosecution. The Secretary is authorized to bar from participation practitioners or providers who submit false or excessive claims (sections 1862 and 1866 of the Social Security Act) and is required to bar from participation those individuals who have been convicted of a criminal offense with respect to medicare or medicaid (section 1128).

Under both medicare and medicaid, acts of knowing and willful fraud as well as bribes and kickbacks are felonies punishable by a maximum fine of \$25,000 or 5-years imprisonment (sections 1877 and 1909). However, such cases must be forwarded by HHS to the Department of Justice. Due to a large volume of cases, the U.S. Attorneys' offices are able to prosecute only those cases which involve a significant amount of money or which warrant imprisonment. As a result, such criminal penalties have proved an ineffective deterrent to fraudulent practices under medicare and medicaid. The Secretary is currently authorized to impose a civil money penalty only in cases where such a penalty has been recommended by a Professional Standards Review Organization.

EXPLANATION OF PROVISION

The bill authorizes the Secretary of Health and Human Services to impose a civil money penalty of not more than \$2,000 for each item or service under a fraudulent claim for reimbursement under the medicare or medicaid programs. In addition to the penalty, the Secretary would also be authorized to impose an assessment of not more than twice the amount claimed for each item or service and to bar from participation in medicare, and the Federal portion of medicaid, any person determined to have filed a fraudulent claim.

The Secretary could impose a penalty in cases where the Secretary determines that the person knew or had reason to know that the item or service was not provided as claimed; where such person had been barred from participation under another provision of the Social Security Act; or where the claim was submitted in violation of an agreement between the person and the Federal or State government.

Proceedings to impose a civil money penalty would be initiated only as authorized by the Department of Justice pursuant to procedures agreed upon by both the Departments of Justice and HHS. Before the Secretary could impose a penalty or bar a person from participation, the Secretary would be required to give written notice and an opportunity for a determination on the record after a hearing at which the person would be entitled to be represented by counsel, to present witnesses and to cross-examine the witnesses against him. In a case in which the Secretary intended to take action to bar a person from participation, the Secretary would be required to provide notice of such action to the appropriate State medicaid agency.

In determining the amount of the penalty assessed, the Secretary would be required to take into account the nature of the claims and the circumstances under which they were presented as well as the degree of culpability, history of prior offenses, and financial condition of the person presenting the claim.

Any person against whom a penalty was assessed or who was barred from participation under this provision would be entitled to Federal judicial review of a final determination of the Secretary by requesting such a review within 60 days after he was notified of the Secretary's order. In the proceeding before the court, the finding of the Secretary with respect to questions of fact, if supported by substantial evidence on the record, would be conclusive.

In any case in which the penalties and assessments imposed by the Secretary with respect to services rendered during a 2-year period exceeded \$15,000 or where the person was barred from participation for a period exceeding 5 years, the person would be entitled to a trial de novo in Federal court. No penalty or assessment would be collected, nor payment prohibited, until all rights to administrative and judicial review had been exhausted. Upon such final determination, the Secretary would be required to provide notice to the public with respect to any person barred from participation in the medicare or medicaid programs.

Amounts recovered as a result of a medicaid claim would be returned to the State in proportion to its medicaid matching share; amounts representing a medicare claim would be returned to the medicare trust

funds, and the remainder would be deposited in the general fund of the U.S. Treasury.

The civil money penalty provided for in this bill is intended to provide an alternative to criminal proceedings so as to increase the effectiveness of enforcement in the medicare and medicaid programs. There are presently numerous cases identified by the Inspector General of HHS which are clear cases of fraud but which are not prosecuted by the Justice Department because they are excessively time consuming or do not warrant imprisonment. It is hoped that this mechanism will provide the Secretary with additional flexibility in pursuing cases of fraud under the programs.

While the Committee believes that civil money penalty proceedings are necessary for the effective prevention of abuses in the medicare and medicaid programs, the Committee is concerned that such proceedings not be initiated lightly. It is anticipated that the Secretary will administer the civil penalty judiciously, using it only where the severity of the violation so warrants. Further, the Committee expects that cases initiated under this provision will be subject to full investigation and substantiation and that alleged violators will receive procedural rights consistent with administrative due process.

The provision would become effective upon enactment.

b. Utilization Guidelines for Provision of Home Health Services (Section 432)

PRESENT LAW AND BACKGROUND

As a condition of payment for home health services, present law requires a physician to certify that the services are required because the patient is homebound and needs intermittent skilled nursing care or physical therapy, speech therapy or, as of July 1, 1981, occupational therapy, and that the physician establish and periodically review a plan of care. Medicare law excludes from coverage services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Despite these provisions, relatively little has been accomplished by way of review of home health services in the light of specific coverage criteria. The Committee is concerned that over the last several years utilization of home health benefits has increased dramatically compared to all other medicare benefits. Of particular concern is the rapid increase in the utilization of home health aide services. Although a range of services is covered under the medicare home health benefit, home health aide visits account for a large proportion of all covered visits.

EXPLANATION OF PROVISION

The bill requires that the Secretary of Health and Human Services establish utilization guidelines and issue instructions to medicare intermediaries for a program of post-payment coverage review of submitted claims, on a sample basis, to monitor compliance with the medical necessity and other requirements of present law for medicare coverage of home health services.

It is the Committee's intent that the Secretary initiate a program of post-payment review of home health services and issue instructions to intermediaries to carry out this review. In addition, the Committee expects the Secretary of HHS, to the extent feasible, to review coverage instructions to intermediaries for clarity and to work to assure consistency of interpretation among intermediaries.

This section requires the Secretary of HHS to establish and provide for the implementation of utilization guidelines not later than October 1, 1981.

c. Repeal of Statutory Time Limitation on Agreements With Skilled Nursing Facilities (Section 433)

PRESENT LAW AND BACKGROUND

In order to renew an agreement with medicare, a skilled nursing facility must undergo a survey to confirm its compliance with applicable health and safety requirements. In the Committee's judgment, it is no longer necessary for every participating skilled nursing facility to be subjected to the annual survey and certification process since program experience indicates that many facilities have been consistently in compliance with the medicare conditions of participation.

EXPLANATION OF PROVISION

The bill repeals the provision in present law that requires skilled nursing facility provider agreements with medicare to be renewed on an annual basis. By enabling the Secretary to be flexible in scheduling surveys of participating skilled nursing facilities, as is currently the case with hospitals, the Committee believes that the ability of the State agencies (which conduct medicare surveys) to concentrate their resources on surveys of those facilities that merit closer scrutiny will be greatly enhanced.

Under the Committee's bill, it is expected that the practice of annually surveying those facilities that have a record of significant deficiencies would be continued; however, the bill would permit surveys at less frequent intervals for a facility with a record of consistent compliance with the standards. It is the Committee's intent that such intervals would be consistent with the practice generally followed by the Secretary in surveying hospitals, and that only in exceptional cases would a skilled nursing facility be surveyed less frequently than at 24-month intervals.

This section is effective on enactment.

d. Technical Corrections for Errors Made by the Medicare and Medicaid Amendments of 1980 (Section 434)

PRESENT LAW AND BACKGROUND

Several technical drafting errors were included in present law by the Medicare and Medicaid Amendments of 1980 (Title IX of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980). The most significant of these errors is the deletion from prior law of a pro-

vision limiting medicare part B reimbursement to the lower of the provider's customary charge or the reasonable cost of the covered service.

EXPLANATION OF PROVISION

The bill restores the provision that was erroneously deleted, and makes several other minor technical and clerical corrections.

The technical corrections generally are effective retroactively to correspond with the effective dates of the Public Law 96-499 provisions that they correct.

e. Repeal of Periodic Interim Payment Change (Section 435)

PRESENT LAW AND BACKGROUND

Under current reimbursement arrangements, hospitals may receive payments for services provided to medicare beneficiaries under two different procedures. The standard procedure is for hospitals to submit bills and receive payments on the basis of those bills. The average time lag between the date of service and the date of payment under the standard procedure is approximately six weeks, of which the medicare processing time is approximately ten to fourteen days. The alternative procedure permits hospitals to receive periodic interim payments (PIP), which are not directly tied to the receipt of bills. On the average, this procedure produces only a three-week lag between the rendition of service and receipt of payment.

Public Law 96-499 imposed a one-time delay in the flow of PIP payments to hospitals and directed the Secretary of HHS to develop and apply procedures under which, with respect to the last 21 days for which PIP payments would otherwise be made during fiscal year 1981, such payments would have been deferred until fiscal year 1982.

EXPLANATION OF PROVISION

The bill would repeal the periodic interim payment change made in Public Law 96-499, thus avoiding a temporary postponement of medicare payments to hospitals that would otherwise occur at the end of fiscal year 1981. The provision is effective upon enactment.

f. Statutory Deadlines for Implementing AFDC Home Health Aide Demonstration Projects (Section 436)

PRESENT LAW AND BACKGROUND

Public Law 96-499 required the Secretary of HHS to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides. Such aides would provide authorized services to elderly or disabled individuals who otherwise might be expected to require institutional care. Ninety percent Federal matching is provided under the States' medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The provision was

effective upon enactment, but no specific implementation dates were included in the law. The Committee is concerned about delays by the Department of HHS in getting these demonstration projects underway.

EXPLANATION OF PROVISION

The bill requires the Secretary of HHS to establish, by October 1, 1981, such guidelines and regulations as are necessary to assure that agreements with States authorized by present law are entered into not later than January 1, 1982, for the training of AFDC recipients as homemakers and home health aides, and requires a report to Congress, during January 1982, on current and anticipated progress, including a description of the agreements entered into by that time and a timetable for the conclusion of any other agreements that the Secretary anticipates.

5. PART E: AMENDMENTS RELATING TO PROFESSIONAL STANDARD REVIEW ORGANIZATIONS (PSRO'S) AND UTILIZATION REVIEW

a. Reduction and Repeal of Professional Standards Review Organizations (PSRO's) (Sections 441-444 and 447-449)

PRESENT LAW AND BACKGROUND

Under present law, PSRO's are charged with the comprehensive and ongoing review of the services provided under medicare, medicaid and the maternal and child health programs. PSRO's determine, for purposes of reimbursement under these programs, whether services are: (1) medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

PSRO's are formed by organizations representing substantial numbers of practicing physicians in 194 geographic areas nationwide. There are currently 47 fully designated and 140 conditionally designated PSRO's in operation.

The major focus of the PSRO program has been on review of inpatient hospital services. While PSRO's are also charged with review responsibilities in other health care settings, budget restrictions have limited review outside the hospital setting.

EXPLANATION OF PROVISION

Under the bill, the Secretary of Health and Human Services would be required to develop and apply specific criteria for the evaluation of the performance of PSRO's. On the basis of such evaluations, the Secretary would be permitted to terminate no more than one-half of all PSRO's prior to October 1, 1982. States would have the option of contracting with PSRO's for medicaid review at a 75-percent Federal matching rate. The PSRO program would be repealed, effective with the end of fiscal year 1983.

Under Sections 441-444 of the bill, the Secretary of HHS would be required, by September 30, 1981, to establish specific criteria for evaluation of the performance of PSRO's. Those criteria would take

into account the PSRO's effectiveness in monitoring the quality of care, managing its activities efficiently, reducing unnecessary utilization and such other criteria as the Secretary may determine appropriate. Based on the criteria so established, the Secretary would be required to assess the performance of PSRO's and determine their relative effectiveness.

The Secretary would then be authorized to terminate the least effective PSRO's, but in no case would the Secretary be permitted to take action which would result in the termination or nonrenewal of more than one-half of all PSRO's prior to October 1, 1982.

Since its inception in 1972, the PSRO program has been the center of considerable controversy regarding its effectiveness in meeting the goals of assuring the quality and efficiency of health care. While the Congressional Budget Office has concluded that, on the whole, the program has been only moderately effective in reducing medicare costs the Committee heard considerable testimony indicating that certain PSRO's had been very effective in controlling health care cost and improving the quality of patient care.

Under the provisions of the bill, the Secretary would be required to establish criteria for evaluating the relative effectiveness of PSRO's. It is the intent of the Committee that such criteria would be established in consultation with individuals and organizations with experience in conducting peer review. The criteria would then be applied in such a way as to terminate those PSRO's which have been the least effective in controlling costs or reviewing the quality of care.

A number of PSRO's have established effective mechanisms for the collection and utilization of data on hospitals within the PSRO area. This information has proved useful in assisting PSRO's, hospitals, and the medical community to determine patterns of utilization and patient care and to reduce unnecessary utilization and improve the quality of care. It is anticipated that such effective collection and use of data will be included among the criteria used to evaluate PSRO performance.

Under the bill, a PSRO would receive 90 days notice of termination. The present law right of a PSRO to a hearing in the case of termination of an agreement would be repealed except with respect to a PSRO with an annual agreement in existence on the date of enactment. Termination of an agreement by the Secretary under this provision would not be subject to judicial review.

Under current law, the Secretary is required to make payments to a PSRO for expenses incurred in the performance of its duties from the medicare trust funds and from general revenue appropriations in proportion to the costs attributable to each of the programs reviewed. The costs of administration and review with respect to the medicare program are paid from the hospital insurance trust fund.

It is the intent of the Committee that, with respect to those PSRO's which have not been terminated and which continue to perform the activities provided for in their agreement with the Secretary, funds will continue to be expended from the medicare trust fund, for purposes of PSRO administration and review of medicare services, at no less than the PSRO's allocation based upon the funding level set forth in the fiscal year 1981 continuing resolution.

Under the bill, recent limitations placed on the scope of review by PSRO's would be removed to provide more flexibility for the remaining PSRO's. Authority would be returned to the Secretary to permit a PSRO to review ancillary, ambulatory, or long-term care services. In addition, PSRO's would be authorized, rather than required, to delegate review activities to hospitals, skilled nursing facilities and intermediate care facilities.

In the face of the severe budget limitations on PSRO's, the Secretary was authorized to permit PSRO review of certain ancillary and other services only where the cost effectiveness of such review had already been demonstrated. The purpose of this provision was to assure that review was focused in those areas where PSRO's were proven to be the most effective. However, as the number of PSRO's is reduced, the Secretary should be empowered to give an individual PSRO the maximum flexibility in achieving savings.

With respect to medicaid review, section 443 of the bill would provide States with the option of contracting with PSRO's at a 75-percent Federal matching rate. Currently, the Secretary contracts with a PSRO to do both medicare and medicaid review with the Federal Government financing 100 percent of the cost. Under the bill, a PSRO would be required to enter into a contract with the State at the State's option for medicaid review under terms and conditions similar to those contained in an agreement between a PSRO and the Federal Government. Such review could not be inconsistent with performance of review under the basic PSRO law. The Committee anticipates that those PSRO's which have been effective in reducing hospital costs within the State will continue to be funded by the State for purposes of medicaid review.

The Secretary of HHS would be required to report to the Congress by September 30, 1982, on the terminations of PSRO's occurring to that date and on the performance of the remaining PSRO's.

Under section 447 of the bill, the PSRO program would be repealed, effective October 1, 1983.

Section 448 of the bill makes certain conforming changes, and section 449 provides certain transitional amendments. Section 449 specifically provides that certain PSRO authority and duties shall remain in effect until October 1, 1983. The section also provides for a transition period with respect to certain provisions of current law. With respect to current PSRO authority, the bill specifically provides that the conclusiveness of a PSRO's determinations, its authority to deny payments, and the limitations on liability of its members and employees shall remain in effect with respect to actions taken before October 1, 1983. As a transition provision, payment for expenses incurred prior to October 1, 1983 would be permitted to be made subsequent to that date. In addition, a beneficiary or provider's right to appeal to the Secretary the decision of a PSRO made prior to October 1, 1983, would continue, as would the Secretary's authority to take action with respect to a provider's participation in medicare based upon a PSRO's recommendation made prior to October 1, 1983. Further, the Secretary would be required to maintain the confidentiality of certain PSRO records as required by present law and would be required to provide for the appropriate disposition of such information in accordance with such requirements of confidentiality.

Section 444 of the bill makes an additional conforming change made necessary by the reduction and ultimate repeal of PSROs. Under current law, as provided for in Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, where a beneficiary no longer requires acute hospital services but must remain in the hospital because no long-term care bed is available in the community, medicare reimbursement is reduced to the long-term care rate, with certain exceptions. Under this provision, the determination as to whether the patient requires acute or long-term care is made by a PSRO. In the absence of PSRO review, the provision would become inoperative.

Under the Committee bill, the Secretary of HHS or such agent as the Secretary may designate, would be authorized in the absence of a PSRO, to carry out such review.

The section would become effective upon enactment.

b. Repeal of Utilization Review Requirements (Section 445)

PRESENT LAW AND BACKGROUND

Under present medicare law, in the absence of a Professional Standards Review Organization (PSRO), hospitals and skilled nursing facilities are required to review, on a sample or other basis, admissions, duration of stay, and use of health facilities and services. This utilization review may be conducted within the institution or by a group organized by the local medical society. Rural health clinics are required to conduct utilization review to the extent the Secretary of HHS determines is necessary and feasible.

EXPLANATION OF PROVISION

The bill would repeal the statutory requirement for utilization review under medicare with respect to hospitals, skilled nursing facilities and rural health clinics. It is anticipated that hospitals will continue to conduct utilization review based upon the present requirements of the Joint Commission on the Accreditation of Hospitals (JCAH). Medicare would continue to reimburse for the costs of utilization review where conducted voluntarily by a provider or pursuant to the JCAH requirement.

The section is effective upon enactment.

6. PART F: MEDICARE AS SECONDARY PAYOR TO THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM (SECTION 451)

PRESENT LAW AND BACKGROUND

Under present law Federal employees are eligible for health insurance protection under the Federal Employees Health Benefits Act (FEHBA). Retired civil service annuitants may receive health insurance coverage by continuing to pay the same monthly premium paid by Federal employees.

The Federal Government pays approximately 60 percent of the total costs of FEHBA premiums. The share which the government actually pays toward the premium of an individual employee or annuitant varies with the plan but may never exceed 75 percent of the premium

cost. There are approximately 120 FEHBA plans including government-wide service and indemnity plans, employee organization plans and health maintenance organizations. Approximately 60 percent of Federal employees belong to the two major government-wide plans.

Individuals age 65 or older who are entitled to social security cash benefits are entitled to hospital insurance coverage under part A of medicare. Thus, those Federal employees and retirees over 65 who have earned sufficient quarters of coverage in social security covered employment may be entitled to both medicare and FEHBA coverage. Approximately 75 to 80 percent of Federal annuitants are dually entitled to social security and civil service retirement.

All individuals 65 and over may elect to enroll in part B of medicare by paying a monthly premium (\$9.60 as of July 1, 1980). Part B provides coverage of physician and other services, subject to an annual deductible and to coinsurance.

Under current law, for those Federal employees and annuitants who are entitled to coverage under both medicare and FEHBA, medicare is the primary payor. As secondary payor, the FEHBA plan will generally pay those allowable expenses remaining after medicare has paid, but not in excess of the dollar amount which the FEHBA plan would otherwise have reimbursed. In general, this means that the FEHBA plan fills in the medicare deductible and coinsurance amounts, and the medicare program bears the major burden of the costs with respect to those persons who are dually entitled.

EXPLANATION OF PROVISION

The bill provides that, for those Federal employees and annuitants who are entitled to coverage under both medicare part B and FEHBA, medicare would become the secondary payor. Medicare part A would become the secondary payor to the FEHBA program only with respect to those persons reaching age 65 after December 31, 1981.

The bill would prohibit payment under medicare part B to the extent that payment had been made, or could reasonably be expected to be made under a FEHBA plan. As secondary payor, medicare part B would pay physician and other expenses remaining after the FEHBA plan had paid, but not more than the maximum dollar amount that medicare would otherwise have paid. In no case could the total of the medicare and FEHBA payments exceed the amount which the FEHBA plan recognizes as reasonable with respect to the services provided.

With respect to medicare part A, for those individuals turning 65 after December 31, 1981, the FEHBA plan would be the primary payor. Medicare, as secondary payor, would reimburse for hospital and other part A services based on reasonable cost up to the dollar amount which medicare would otherwise have paid. The Secretary would be required to coordinate benefits in such a manner as to assure that the total amount paid for part A services by medicare and the FEHBA plan would not exceed the amount recognized by medicare as the reasonable cost of such services.

Hospitals and certain other providers are reimbursed under part A based upon their reasonable costs. The amount payable to the provider

as reasonable is reduced by the amount of the part A inpatient deductible and coinsurance. The provider is then permitted to bill the medicare beneficiary for the deductible and coinsurance amounts. Under the bill, the Secretary of Health and Human Services would be authorized to establish a method for coordinating the payment of benefits under the two programs and would be required to limit the provider's charges to the beneficiary of deductible and coinsurance amounts such that, when added to the amounts payable under medicare and the FEHBA plan, they would not exceed the amount recognized as reasonable under medicare. With respect to other charges which may be imposed upon beneficiaries under present law, such as those permitted under section 1866(a)(2)(B) and (C), the Secretary may establish by regulation such limits as he or she may deem appropriate in order to assure that any charges which could otherwise be imposed on the beneficiary will be reduced by amounts paid under FEHBA.

In general, Federal civil service retirees who qualify for social security and thus medicare part A benefits, do so on the basis of a much shorter period of social security covered employment than do other retirees. For those individuals who are dually entitled to medicare part A and FEHBA, or for those persons who enroll in medicare part B and the FEHBA plan, the medicare program bears the largest portion of covered health care costs.

The intent of the provision is to eliminate the subsidy presently being indirectly provided by medicare to the FEHBA program and to distribute more equitably between the programs the costs of medical care for Federal employees and retirees 65 and over.

The provision would become effective with respect to part B for services furnished on or after January 1, 1982, or the first pay period beginning after January 1, 1982, whichever is later. With respect to part A, the above effective date would apply only to services furnished to individuals who are 65 years of age or older after December 31, 1981.

III. BUDGET EFFECTS OF THE BILL

A. Committee Statement

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made relative to the budget effects of the provisions of H.R. 3850, as reported by the Committee.

With respect to the spending reductions contained in the bill the Committee states that it agrees with the estimates of the Congressional Budget Office (CBO) attached below with one exception. The estimates for counting the income of stepparents in the AFDC program should be \$22 million higher for each of the fiscal years 1982-86. The Committee feels that this is a more accurate estimate of the impact of the Committee provision for the following reasons:

A. When this was initially estimated by the Administration and CBO, AFDC benefit reductions totaled \$162 million, AFDC administrative cost savings were \$109 million, and food stamp cost increased by \$160 million for a total net federal savings of \$131 million. Tabulations from the March, 1979 AFDC characteristics survey shows that over 95 percent of the families affected by the provision currently are not receiving food stamp benefits, therefore it seems unreasonable to assume that there would be \$60 million of increased food stamp costs. In addition, income eligibility levels were lowered in the food stamp program as a result of the reconciliation instruction process and thus this much additional cost seems even more unlikely.

B. In addition, embodied in the Congressional Budget Office cost estimate is an assumption regarding marital behavior that is based on quite limited statistical data and does not appear from the limited information available to be appropriate.

In addition, the Committee approved changes in the trade adjustment assistance program were preliminarily estimated by the Congressional Budget Office to result in a savings of \$1,335 million in fiscal year 1982. This estimate was consistent with the estimates and assumptions on which the reconciliation instruction to the Ways and Means Committee was based. As a result, the Committee has calculated the trade adjustment changes to have a net effect of reducing outlays of \$1,335 million.

With respect to the reduction in budget authority mandated in the Conference Report on H. Con. Res. 115, the Committee makes the following statement:

(1) The budget resolution does not recognize the unique characteristics of the entitlement programs within the jurisdiction of the Committee on Ways and Means. For example, when outlays reductions are made to entitlement programs financed from trust funds, the trust

funds accumulate additional interest and this accrued interest results in increases in budget authority.

(2) The budget resolution also assumes a certain distribution of reductions between trust fund entitlement programs and entitlement programs financed from general revenues. Budget authority in the context of trust funds is basically revenue to those trust funds. Thus spending reductions to trust fund entitlement programs are scored as both increases in budget authority (because of accrued interest) and the appropriate level in outlays reductions. Since the Committee has reduced spending in the trust fund entitlement programs by more than the budget resolution assumed, outlay reductions are met while the budget authority target is not.

B. Congressional Budget Office Estimates

In compliance with subdivision (C) of clause 2(1)(3) of rule XI of the Rules of the House of Representatives, the Committee states that the Congressional Budget Office has examined H.R. 3850, as reported by the Committee, and H.R. 2540, as previously reported by the Committee and has submitted the following statements.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., June 11, 1981.

HON. DAN ROSTENKOWSKI,

Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to section 202 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimates of the bill for reducing spending in programs within the jurisdiction of the Committee on Ways and Means.

The savings estimates have been calculated from the CBO baseline used by the Budget Committees in developing the reconciliation instructions.

The estimates included in the attached report represent the 1981-1986 effects on the Federal budget of the Committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimates.

Sincerely,

ALICE M. RIVLIN,
Director.

BUDGET AUTHORITY AND OUTLAY ESTIMATES OF HOUSE WAYS AND MEANS RECONCILIATION PROVISIONS

[In millions of dollars]

	Fiscal year—					
	1981	1982	1983	1984	1985	1986
TRADE						
Trade adjustment benefits: ¹						
Budget authority.....		-1,295	-800	-450	-450	-450
Outlay.....		-1,295	-800	-450	-450	-450
Reduction in authorizations for customs service, and trade adjustment assistance for firms and communities:						
Budget authority.....		-38	-37	-40	-44	-48
Outlay.....		-35	-37	-40	-44	-48
Total, trade:						
Budget authority.....		-1,333	-837	-490	-494	-498
Outlay.....		-1,330	-837	-490	-494	-498
SOCIAL SECURITY						
Phaseout postsecondary student benefits:						
Budget authority.....		13	56	143	275	443
Outlay.....		-347	-796	-1,439	-1,840	-2,153
Termination of mother's and father's benefits when child attains age 16:						
Budget authority.....		1	6	28	68	113
Outlay.....		-30	-88	-496	-528	-560
Elimination of minimum benefit:						
Budget authority.....		22	60	87	124	141
Outlay.....		-45	-85	-95	-125	-169
Rounding of benefits:						
Budget authority.....		3	17	40	69	102
Outlay.....		-80	-280	-323	-367	-411
Pension Reform Act:						
Budget authority.....		0	0	0	1	2
Outlay.....		-1	-2	-5	-8	-10
Discontinue trust fund financing of vocational rehabilitation services:						
Budget authority.....		3	10	16	23	29
Outlay.....		-87	-86	-73	-73	-53
Reduce retirement exempt age to 71 in 1982:						
Budget authority.....		8	18	23	24	26
Outlay.....		-210	-70	0	0	0
Pay one-half of 1982 benefit increase in July and the remainder plus 2 additional months of CPI increases in October:						
Budget authority.....		46	151	219	307	372
Outlay.....		-1,800	-721	-942	-754	-726
Limit lump-sum death benefit:						
Budget authority.....		9	25	42	61	83
Outlay.....		-200	-210	-215	-220	-230
Restore retirement exempt age additionally from 71 to 72 in 1982:						
Budget authority.....		6	15	17	18	19
Outlay.....		-170	-50	0	0	0
Pay benefits with 1st of month:						
Budget authority.....		14	23	42	64	88
Outlay.....		-190	-220	-240	-260	-280
Total, social security:						
Budget authority.....		125	381	657	1,034	1,418
Outlay.....		-3,160	-2,608	-3,828	-4,175	-4,592
UNEMPLOYMENT COMPENSATION						
Repeal national trigger:						
Budget authority.....		-300	0	0	0	0
Outlay.....		-657	0	0	0	0
Exclude extended benefit claimants from State trigger calculations:						
Budget authority.....		-400	-600	-100	0	0
Outlay.....		-561	-380	-120	-10	0
Reduce unemployment compensation for ex-military personnel:						
Budget authority.....		-160	-160	-160	-160	-160
Outlay.....		-160	-160	-160	-160	-160
Total, unemployment compensation:						
Budget authority.....		-860	-760	-260	-160	-160
Outlay.....		-1,378	-540	-280	-170	-160

See footnotes at end of table.

**BUDGET AUTHORITY AND OUTLAY ESTIMATES OF HOUSE WAYS AND MEANS RECONCILIATION
PROVISIONS—Continued**

[In millions of dollars]

	Fiscal year—					
	1981	1982	1983	1984	1985	1986
AID TO FAMILIES WITH DEPENDENT CHILDREN						
Limit earnings disregards:						
Budget authority.....	—150	—154	—159	—162	—164	—164
Outlay.....	—150	—154	—159	—162	—164	—164
Count income of stepparents:						
Budget authority.....	—108	—111	—113	—116	—118	—118
Outlay.....	—108	—111	—113	—116	—118	—118
Require retrospective accounting and monthly reporting:						
Budget authority.....	0	—187	—195	—201	—207	—207
Outlay.....	0	—187	—195	—201	—207	—207
Allow States to require certain recipients to participate in job search:						
Budget authority.....	0	—12	—25	—32	—33	—33
Outlay.....	0	—12	—25	—32	—33	—33
Define unemployed parent as the principal earner for family:						
Budget authority.....	0	0	0	0	0	0
Outlay.....	0	0	0	0	0	0
Require States to recover AFDC overpayments and pay underpayments:						
Budget authority.....	—115	—110	—106	—102	—98	—98
Outlay.....	—115	—110	—106	—102	—98	—98
Optional payments for dependent children over 18:						
Budget authority.....	—25	—35	—45	—50	—55	—55
Outlay.....	—25	—35	—45	—50	—55	—55
Deem sponsor's income to aliens in AFDC families:						
Budget authority.....	—15	—15	—15	—15	—15	—15
Outlay.....	—15	—15	—15	—15	—15	—15
Limit allowable resources to \$1,500:						
Budget authority.....	—10	—10	—10	—10	—10	—10
Outlay.....	—10	—10	—10	—10	—10	—10
Administrative savings:						
Budget authority.....	—40	—45	—50	—55	—60	—60
Outlay.....	—40	—45	—50	—55	—60	—60
Medicaid savings:						
Budget authority.....	—40	—55	—60	—65	—70	—70
Outlay.....	—40	—55	—60	—65	—70	—70
Total, AFDC:						
Budget authority.....	—503	—734	—778	—808	—830	—830
Outlay.....	—503	—734	—778	—808	—830	—830
CHILD SUPPORT ENFORCEMENT						
Collection of support for adults:						
Budget authority.....	—23	—23	—23	—23	—23	—23
Outlay.....	—23	—23	—23	—23	—23	—23
Modify collection for non-AFDC families:						
Budget authority.....	—45	—49	—55	—59	—65	—65
Outlay.....	—45	—49	—55	—59	—65	—65
Source of incentive payments to cooperating jurisdiction:						
Budget authority.....	—61	—69	—78	—87	—98	—98
Outlay.....	—61	—69	—78	—87	—98	—98
Prohibit discharge of child support in bankruptcy:						
Budget authority.....	—17	—21	—26	—33	—41	—41
Outlay.....	—17	—21	—26	—33	—41	—41
Child support intercept of unemployment benefits:						
Budget authority.....	—20	—20	—20	—20	—20	—20
Outlay.....	—20	—20	—20	—20	—20	—20
Total, child support enforcement:						
Budget authority.....	—166	—182	—202	—220	—247	—247
Outlay.....	—166	—182	—202	—220	—247	—247

See footnotes at end of table.

**BUDGET AUTHORITY AND OUTLAY ESTIMATES OF HOUSE WAYS AND MEANS RECONCILIATION
PROVISIONS—Continued**

[In millions of dollars]

	Fiscal year—					
	1981	1982	1983	1984	1985	1986
SUPPLEMENTAL SECURITY INCOME						
Change from a quarterly prospective to a retrospective accounting period:						
Budget authority.....	-30	-60	-60	-60	-60	-60
Outlay.....	-30	-60	-60	-60	-60	-60
Eligibility of SSI recipients for food stamps:						
Budget authority.....	-50	-50	-50	-50	-50	-50
Outlay.....	-50	-50	-50	-50	-50	-50
Negotiability of SSI checks:						
Budget authority.....	-7	0	0	0	0	0
Outlay.....	-7	0	0	0	0	0
Pay $\frac{1}{2}$ of 1982 benefit increase in July and the remainder plus 2 additional months of CPI increases in October:						
Budget authority.....	-80	-28	-36	-29	-28	-28
Outlay.....	-80	-28	-36	-29	-29	-28
Total, SSI:						
Budget authority.....	-167	-138	-146	-139	-138	-138
Outlay.....	-167	-138	-146	-139	-139	-138
LOW-INCOME ENERGY ASSISTANCE						
Low-income energy assistance:						
Authority level ²	-847	-947	-1,067	-1,209	-1,413	-1,413
Outlay.....	-847	-947	-1,067	-1,209	-1,209	-1,413
SOCIAL SERVICES						
Limit Federal title XX training funds to \$75,000,000 for fiscal 1982:						
Budget authority.....	-7	0	0	0	0	0
Outlay.....	-7	0	0	0	0	0
HEALTH						
Repeal periodic interim payment change:						
Medicare:						
Budget authority.....	2	(³)	0	0	0	0
Outlay.....	685	-692	0	0	0	0
Civil money penalty:						
Medicare:						
Budget authority.....	-7	-7	-7	-7	-7	-7
Outlay.....	-7	-7	-7	-7	-7	-7
Medicaid:						
Budget authority.....	-14	-14	-14	-14	-14	-14
Outlay.....	-14	-14	-14	-14	-14	-14
Less frequent SNF surveys:						
Medicare:						
Budget authority.....		(³)	(³)	1	1	1
Outlay.....		-4	-4	-4	-4	-4
Eliminate utilization review:						
Medicare:						
Budget authority.....	0	0	0	0	0	0
Outlay.....	0	0	0	0	0	0
Medicaid:						
Budget authority.....	0	0	0	0	0	0
Outlay.....	0	0	0	0	0	0
Reduction in number of PSRO's:						
Medicare:						
Budget authority.....	-11	-22	-5	-4	-9	-9
Outlay.....	-17	-33	-7	53	61	61
Medicaid:						
Budget authority.....	-4	-8	-2	-19	-33	-33
Outlay.....	-4	-8	-2	-19	-19	-33
Renal dialysis reimbursement rate:						
Medicare:						
Budget authority.....	-105	-130	-155	-180	-205	-205
Outlay.....	-105	-130	-155	-180	-180	-205

See footnotes at end of table.

**BUDGET AUTHORITY AND OUTLAY ESTIMATES OF HOUSE WAYS AND MEANS RECONCILIATION
PROVISIONS—Continued**

[In millions of dollars]

	Fiscal year—					
	1981	1982	1983	1984	1985	1986
Part B deductible carryover:						
Medicare:						
Budget authority.....		-55	-55	-55	-55	-55
Outlay.....		-55	-55	-55	-55	-55
Medicaid:						
Budget authority.....		4	4	4	4	4
Outlay.....		4	4	4	4	4
Base part A coinsurance on current year deductible:						
Medicare:						
Budget authority.....		(*)	1	2	2	3
Outlay.....		-5	-10	-10	-10	-10
Medicaid:						
Budget authority.....		0	1	1	1	1
Outlay.....		0	1	1	1	1
Medicare as second payor to FEHB program:						
Medicare:						
Budget authority.....		-110	-205	-195	-170	-145
Outlay.....		-131	-300	-360	-400	-430
Other agency costs:						
Authorization level.....		60	140	170	190	200
Outlay.....		60	140	170	190	200
Off-budget costs:						
Budget authority.....		15	40	45	50	55
Outlay.....		15	40	45	50	55
Repeal freestanding detoxification facilities:						
Medicare:						
Budget authority.....		0	0	0	0	0
Outlays.....		0	0	0	0	0
Limits on reimbursement to home health agencies to the 75th percentile:						
Medicare:						
Budget authority.....		(*)	2	4	6	9
Outlay.....		-12	-23	-27	-30	-33
Make the part A inpatient deductible and coinsurance more current:						
Medicare:						
Budget authority.....		7	25	55	85	120
Outlay.....		-185	-305	-360	-410	-490
Medicaid:						
Budget authority.....		15	25	30	35	40
Outlay.....		15	25	30	35	40
Increase part B deductible to \$70 and index in future years:						
Medicare:						
Budget authority.....		-90	-215	-330	-425	-520
Outlay.....		-90	-215	-330	-425	-520
Medicaid:						
Budget authority.....		7	15	25	35	40
Outlay.....		7	15	25	35	40
Require utilization guidelines for home health services:						
Medicare:						
Budget authority.....		0	0	0	0	0
Outlay.....		0	0	0	0	0
Lower sec. 223 limits on routine hospital costs to 108 percent of the mean:						
Medicare:						
Budget authority.....		3	10	20	30	40
Outlay.....		-75	-105	-125	-140	-170
Medicaid:						
Budget authority.....		-13	-18	-20	-25	-30
Outlay.....		-13	-18	-20	-25	-30
Eliminate occupancy test for hospital long-term care except for public hospitals:						
Medicare:						
Budget authority.....		2	8	15	20	30
Outlay.....		-61	-70	-80	-90	-105
Medicaid:						
Budget authority.....		-17	-20	-23	-26	-30
Outlay.....		-17	-20	-23	-26	-30

See footnotes at end of table.

**BUDGET AUTHORITY AND OUTLAY ESTIMATES OF HOUSE WAYS AND MEANS RECONCILIATION
PROVISIONS—Continued**

[In millions of dollars]

	Fiscal year—					
	1981	1982	1983	1984	1985	1986
Nutritional therapy as alternative mode of treatment under the ESRD program:						
Medicare:						
Budget authority.....		-20	-25	-30	-30	-35
Outlay.....		-20	-25	-30	-30	-35
Demonstration projects for the training of AFDC recipients as home health aides:						
Medicaid:						
Budget authority.....		0	0	0	0	0
Outlay.....		0	0	0	0	0
Require medicare inpatients to copay \$1 per day from the 1st day of admission to acute care:						
Medicare:						
Budget authority.....		5	15	25	35	45
Outlay.....		-115	-117	-119	-122	-125
Medicaid:						
Budget authority.....		9	9	9	10	10
Outlay.....		9	9	9	10	10
Offset interest income on funded depreciation:						
Medicare:						
Budget authority.....		4	15	25	35	50
Outlay.....		-100	-120	-140	-160	-190
Medicaid:						
Budget authority.....		-15	-20	-25	-25	-30
Outlay.....		-15	-20	-25	-25	-30
Subtotal, health:						
Budget authority/authorization level.....	-2	-345	-469	-475	-491	-520
Outlay.....	685	-1,642	-1,405	-1,645	-1,844	-2,160
Off-budget:						
Budget authority.....		15	40	45	50	55
Outlay.....		15	40	45	50	55
Total:						
On-budget:						
Budget authority/authorization level.....	-2	-4,103	-3,686	-2,761	-2,487	-2,388
Outlay.....	685	-9,200	-7,391	-8,436	-9,059	-10,038
Off-budget:						
Budget authority.....		15	40	45	50	55
Outlay.....		15	40	45	50	55

¹ CBO provided preliminary savings estimates to the budget committees at the time reconciliation instructions were issued of \$1,335, \$840, and \$600 for 1982 through 1984.

² Assumes authorization levels of \$1,800 million, \$2,000 million, and \$2,200 million in 1984 through 1986.

³ Negligible.

IV. OTHER MATTERS TO BE DISCUSSED UNDER HOUSE RULES

A. Vote of the Committee

In compliance with subdivision (B) of clause 2(1)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the Committee on the motion to report H.R. 3850, as amended.

H.R. 3850, as amended, was ordered favorably reported by a voice vote.

B. Oversight Findings

In compliance with subdivision (A) of clause 2(1)(3) of rule XI of the Rules of the House of Representatives, the following statement is made with respect to the Committee's oversight findings.

TRADE

The Committee has conducted extensive oversight of the operation and effectiveness of the trade adjustment assistance programs through several sets of hearings held by its Subcommittee on Trade since 1976 and through consideration of legislative amendments to these programs. In conjunction with this oversight, the General Accounting Office has provided the Congress a series of reports as required by section 280 of the Trade Act of 1974 evaluating the current programs and recommending modifications in them. In its most recent hearings on March 30 and 31, 1981, the Subcommittee on Trade received testimony from Administration officials and representatives of major labor unions and business on proposals by the Administration to reduce Government spending through fundamental changes in the adjustment assistance program for workers.

From this oversight activity it has become clear that the worker adjustment assistance program has not functioned as Congress intended. The program has become primarily one of income compensation rather than positive adjustment of import-impacted workers to new employment, as evidenced by the budgetary increase for trade readjustment allowances from \$70 million to \$2.7 billion since 1976 while funding for training, job search, and relocation have never exceeded \$15.5 million annually. Delays in benefit delivery, inequities in worker coverage and benefit levels, and administrative problems have also reduced program effectiveness.

In the context of the spending reductions called for by the Administration in social programs overall, the Committee believes that fundamental changes in worker adjustment assistance program are warranted which place primary focus on adjustment of long-term and permanently unemployed workers and address other program de-

iciencies. The Committee believes that continuation of trade adjustment assistance to relieve economic dislocation that can result for some workers and firms from a Federal policy of trade liberalization is essential as an alternative to import restrictions. Consequently, the Committee has reauthorized the program for workers and firms for an additional year until the end of fiscal year 1983 and intends to maintain close and continual oversight of their operation and effectiveness.

SOCIAL SECURITY

The Social Security Act provides for payment of benefits to children age 18 to 22 of entitled retired, disabled and deceased workers if the child is attending secondary school full time and are not married. Social Security student benefit payments are increased from \$325 million in 1966, the first full year of the program, to \$1.6 million in 1978, and are estimated to reach \$2.5 billion in 1982. The Oversight Subcommittee held hearings on Social Security student benefits in early 1979, during which the Government Accounting Office (GAO) expressed reservations about the program on several grounds: (1) The program is redundant in many cases, since financial assistance for students through the student loan and basic education grant programs, and other sources, has increased significantly since 1966; (2) The program does not target funds efficiently on those who need educational assistance most, since students from lower income (and thus low benefit) families generally receive the least benefits, and students from larger families receive proportionately less than students from small families, regardless of their need for assistance; (3) The student benefit program has an extremely high rate of overpayment—86% of the students in GAO's sample who attended part-time or had dropped out (and thus were ineligible for benefits) did not notify the Social Security Administration as required, and at least 31% of the students who were no longer attending school full time incorrectly reported that they were full-time students. Consistent with these oversight findings, the Committee has recommended to phase out the student benefit for 18 to 22 year-olds who attend post-secondary school over the next six years.

PUBLIC ASSISTANCE

PART A—UNEMPLOYMENT COMPENSATION

(1) *Extended benefits.*—Extended unemployment benefits (EB) are payable to individuals who exhaust their State benefits during periods of high unemployment. EB is paid in all States, regardless of State unemployment rates, when the national insured unemployment rate (IUR) reaches specified levels, referred to as the "national trigger". Consistent with the Committee's oversight findings that EB should be targeted to States with the highest unemployment, repealing the national trigger will eliminate EB in States with otherwise low unemployment rates during periods of high national unemployment. Benefits will be paid only in States with insured rates above the specified levels, so that assistance is targeted to States where economic conditions make it unusually difficult for unemployed workers to find jobs.

Eliminating extended benefits claimants from the calculation of State insured unemployment rates furthers this policy.

(2) *Limitation on unemployment benefits paid to ex-service members.*—In recent years, the number of persons leaving the military before their term of enlistment has expired has been on the increase. Questions have been raised about the number of individuals who serve shortened terms of service on the presumption that unemployment compensation will be available to them. The committee provisions will limit eligibility for unemployment compensation only to those persons who have completed a more lengthy period of service and takes into account a variety of payments for traveling expenses and unused leave paid at the end of enlistment.

PART B. SUBPART 1—AID TO FAMILIES WITH DEPENDENT CHILDREN

The Aid to Families with Dependent Children program is intended to provide grants to the States for needy children and their caretakers. Consistent with the Committees' oversight findings that need for assistance should be accurately determined, that recipients should be assisted in finding employment and that program requirements can be made more uniform, the Committee has made changes in the AFDC program which will:

(1) *Income and resources.*—Modify AFDC earned income and work expense disregards; limit the value of resources permitted for eligibility; and require States to consider available to a child income of a stepparent (living in the same home as the child) which exceeds specified levels;

(2) *Eligibility and benefits.*—Limit the eligibility of two parent families where one parent is unemployed to families in which the principal earner is unemployed; restrict AFDC payments to citizens of the United States and lawfully admitted aliens, and deem the income and resources of the sponsor to an alien in an AFDC family available for three years after his or her entry into the United States; and allow States to require AFDC recipients to participate in work experience assignments in which they would perform work in return for AFDC benefits; and

(3) *Administrative improvements and Federal financial participation.*—Require States to determine monthly benefits on the basis of the recipient's actual income in the previous month; require States to promptly take all necessary steps to correct any overpayments or underpayments; and limit the Federal share of AFDC costs to 57 percent.

PART B. SUBPART 2—CHILD SUPPORT ENFORCEMENT

The Child Support Enforcement Program provides services to both AFDC and non-AFDC families to locate absent parents, establish paternity, and to assist in the establishment and collection of both court-ordered and voluntary child support payments. The program was enacted in 1975 in an effort to require absent parents to support their children and thereby reduce AFDC expenditures.

Consistent with the Committee's oversight finding that child support collection procedures can be improved and Federal adminis-

trative costs reduced, the Committee has made legislative changes in the program to permit child support agencies to enforce existing alimony obligations in AFDC cases, to prohibit the discharge in bankruptcy of child support obligations, to facilitate the satisfaction of child support obligations from unemployment benefits, to allow Internal Revenue Service collection of child support-alimony obligations established by administrative order, to require States to collect fees to defray the cost of collection services to non-AFDC families, and to modify the distribution of incentive payments to States or political subdivisions that collect child support payments on behalf of another jurisdiction.

PART C—SUPPLEMENTAL SECURITY INCOME

The Supplemental Security Income (SSI) program was enacted in 1972 to provide monthly cash assistance to needy, aged, blind, and disabled persons. The amount of payment is based on prospective income for calendar quarters.

As a result of its oversight activities, the Committee approved changes to improve the administration of the program by providing that benefit payments be determined monthly on the basis of income and resources in the preceding month (or at the discretion of the Secretary, the second preceding month); that limit the negotiability of SSI checks to 180 days from the date of issuance (and that the amount from such unnegotiated checks which represent State supplementation payments be returned to the States); and that allow any State which previously increased its supplementary SSI payment to include the bonus value of food stamps, and continues to pass through required Federal cost-of-living increases, to remain in food stamp cash-out status.

PART D—ENERGY ASSISTANCE TO LOW-INCOME HOUSEHOLDS

Low-income families spend an increasing percentage of their incomes on rising household energy costs. The Home Energy Assistance Act of 1980 (title III of Public Law 96-223, the Crude Oil Windfall Profit Tax Act of 1980), authorized for fiscal year 1981 grants to the States for assistance to eligible low-income households to offset rising home energy costs. The authorization for the Home Energy Assistance Act expires September 30, 1981. The Committee believes a comprehensive program targeted to help low-income families offset rising energy costs is needed. Accordingly, the Committee reauthorizes the low-income energy assistance (LIEA) program and finds that each State should receive the same proportion of Federal LIEA funds appropriated in fiscal 82 and 83 that it received of the LIEA funds allotted by formula for fiscal 1981.

Under current law, Federal assistance is provided through grants to States which may be used to aid low-income households through payments to eligible households, their energy suppliers or operators of public housing units. The Committee believes this approach is appropriate and that Federal requirements should not unnecessarily impede States from designing programs which meet their particular needs.

As a result of its oversight activities, the Committee finds that Federal LIEA funds should be limited to families currently receiving federally funded public assistance and other families with incomes below 150 percent of the poverty level or 60 percent of State median income. States should be allowed to purchase and install weatherization materials designed to improve the heating or cooling efficiency of homes of eligible households. In addition, States should be allowed to carryover up to 25 of the funds received in one fiscal year into the next. Funds not used by the States in a fiscal year, and not reserved for use in the forthcoming year, should be reallocated.

PART E—SOCIAL SERVICES

Under current law, 75 percent Federal matching funds are available to States for training costs relating to title XX Social Services activities. Consistent with the Committee's oversight findings, the Committee's bill would continue through fiscal year 1982 the \$75 million limitation on Federal Title XX training funds that was in effect in fiscal 1981. The Committee believes States should receive the same share of the \$75 million in fiscal 1982 as they received in fiscal 1981.

MEDICARE

Oversight hearings and studies conducted in prior years by the Committee's Subcommittees on Health and Oversight have examined various aspects of medicare program operation relating, for example, to PSRO's and to problems of medicare fraud and abuse. In addition, the Subcommittee on Health has inquired into the effectiveness of the medicare program during legislative hearings held on medicare issues on March 30, 31 and on April 1, 1981. The Subcommittees on Oversight and Health have examined the operation of the PSRO program during oversight hearings held on March 24 and 25, 1981. These activities have provided insights into problems in the program and have helped to shape several provisions of the bill, including those affecting PSRO's and establishing authority for civil money penalties.

C. New Budget Authority and Tax Expenditures

In compliance with subdivision (B) of clause 2(1)(3) of rule XI of the Rules of the House of Representatives, the Committee makes the following statements with respect to new budget authority and tax expenditures.

NEW BUDGET AUTHORITY

The Committee advises that H.R. 3850 consists of provisions which do not provide new budget authority. In its spending program recommendations, which have been incorporated into H.R. 3850, the Committee recommended reductions in budget authority totalling \$4,143 million.

TAX EXPENDITURES

The Committee advises that H.R. 3850 includes no new tax expenditures.

97TH CONGRESS }
1st Session }

SENATE

{ REPORT
No. 97-139

OMNIBUS RECONCILIATION ACT OF 1981

REPORT

OF THE

COMMITTEE ON THE BUDGET

UNITED STATES SENATE

TO ACCOMPANY

S. 1377

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO
TITLE III OF THE FIRST CONCURRENT RESOLUTION ON
THE BUDGET FOR FISCAL YEAR 1982 (H. CON. RES. 115,
NINETY-SEVENTH CONGRESS)



JUNE 17 (legislative day, JUNE 1), 1981.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1981

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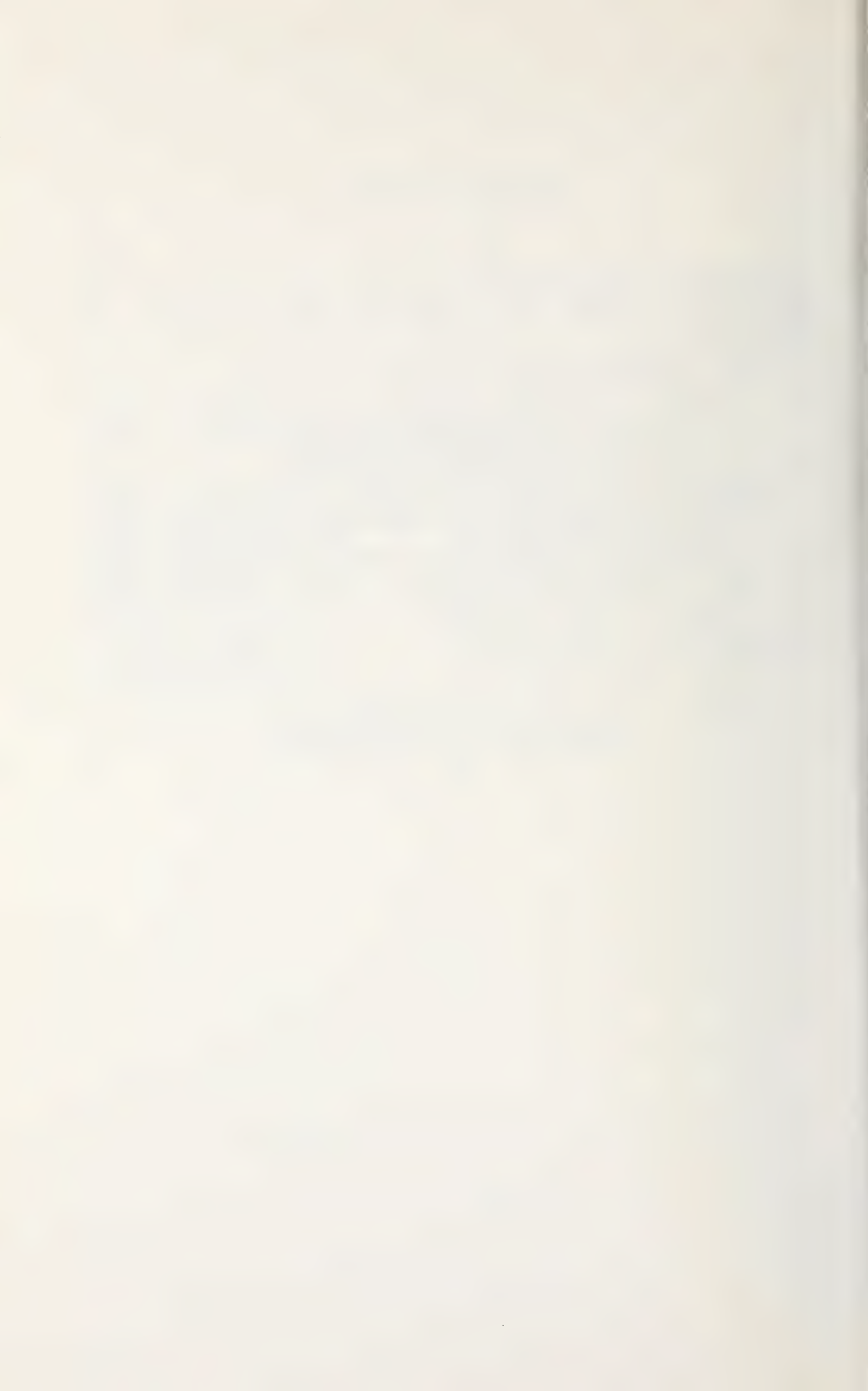
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OMNIBUS RECONCILIATION ACT OF 1981

JUNE 17 (legislative day, JUNE 1), 1981.—Ordered to be printed

REPORT

[To accompany S. 1377]

The Committee on the Budget, to which was submitted reconciliation recommendations pursuant to title III of the First Concurrent Resolution on the Budget for Fiscal Year 1982 (H. Con. Res. 115, Ninety-seventh Congress), having considered the same, reports favorably thereon and recommends that the bill embodying those recommendations do pass.

(1)

Finance

(\$ millions)

	FY 1981		FY 1982		FY 1983		FY 1984	
	BA	0	BA	0	BA	0	BA	0
Direct spending:								
Social services block grant.....	---	---	-939	-939	-1,101	-1,101	-1,248	-1,248
Medicare 4% nursing differential.....	---	-20	---	-130	---	-150	---	-185
Medicaid cap and Federal matching.....	-122	-122	-1,400	-1,010	-1,770	-1,630	-2,360	-2,230
Social security minimum benefit.....	---	-50	---	-970	---	-1,070	---	-1,070
Social security student benefits.....	---	---	---	-567	---	-1,580	---	-2,033
Social security miscellaneous benefits.....	---	-1	---	-112	---	-302	---	-337
Social security death benefit.....	---	-17	---	-200	---	-210	---	-215
SSI retrospective accounting.....	---	---	-30	-30	-60	-60	-60	-60
AFDC.....	---	---	-1,123	-1,123	-1,363	-1,425	-1,425	-1,425
Social security megacap.....	---	-5	---	-50	---	-75	---	-100
Social security work requirement.....	---	---	---	-124	---	-350	---	-629
Unemployment compensation for ex servicemen	-36	-36	-265	-265	-254	-254	-244	-244
UI triggers.....	---	-505	---	-1,218	---	-472	---	-192
UI 20 weeks extended benefits.....	---	---	---	---	---	-11	---	-10
Trade adjustment assistance.....	---	---	---	---	---	-800	---	-450
Medicare periodic payments.....	---	+515	-1,295	-1,295	-800	-800	-450	-450
Social security vocational rehabilitation..	---	---	---	-522	---	---	---	---
SSI vocational rehabilitation.....	---	---	---	-87	---	-86	---	-73
UI loan reform.....	-10	-10	-20	-20	-18	-18	-15	-15
Medicare occupational therapy.....	---	---	-271	-239	-617	-486	-955	-680
Medicare alcohol detoxification.....	---	---	---	-35	---	-41	---	-46
Medicare dental benefits.....	---	---	---	---	---	---	---	---
Medicare open enrollment.....	---	---	---	-12	---	-13	---	-16
Medicare pneumococcal vaccine.....	-1	-1	-9	-9	-10	-10	-11	-11
Medicare civil penalties.....	---	---	-36	-36	-23	-23	-23	-23
Medicare nursing home surveys.....	---	---	-7	-7	-7	-7	-7	-7
Medicare and Medicaid closure and conversion	---	---	-4	-4	---	-4	---	-4
Medicare reasonable charges.....	---	---	---	-2	---	-7	---	-19
Medicare and Medicaid outpatient services..	---	---	-13	-13	-21	-21	-25	-25
Medicare and Medicaid services exclusion...	---	-30	---	-15	---	-23	---	-27
Medicare Part B deductible.....	-5	-5	---	-90	---	-100	---	-115
Medicare Part B carryover.....	---	---	-120	-120	-210	-210	-240	-240
Medicare coordination with Federal	---	---	-55	-55	-55	-55	-55	-55
employees' health benefits.....	---	---	+300	-270	+470	-440	+450	-450

Finance - pg. 2
(\$ millions)

	FY 1981		FY 1982		FY 1983		FY 1984	
	BA	0	BA	0	BA	0	BA	0
Direct spending (continued):								
Medicare and medicaid buy-in.....	---	---	-2	-8	-2	-9	-2	-10
Medicare dialysis.....	---	---	-95	-95	-165	-165	-180	-180
Medicare Part B premiums.....	---	---	---	---	---	---	---	---
Maternal and child health block grant.....	---	---	-147	-50	-175	-132	-208	-182
Committee recommendation.....	-174	-282	-5,527	-9,722	-6,181	-11,278	-7,058	-12,606
Instruction to Committee.....	-212	-286	-4,394	-9,218	-4,563	-10,744	-4,675	-11,589
Authorizations:								
Social services/child welfare (Committee recommendation).....	---	---	-54	-54	-65	-65	-71	-71
Instruction to Committee.....	---	---	-96	-112	-114	-132	-149	-177
Grand total:								
Committee recommendation.....	-174	-282	-5,581	-9,776	-6,246	-11,343	-7,129	-12,677
Instruction to Committee.....	-212	-286	-4,490	-9,330	-4,677	-10,876	-4,824	-11,766

I. SUMMARY OF FINANCE COMMITTEE RECOMMENDATIONS

Social Security Provisions

Elimination of benefits for post-secondary students.—Under current law, monthly cash benefits are paid to the children of an insured worker when the worker retires, becomes disabled, or dies. Because of a provision enacted in 1965, a child's benefits may continue after age 18 and up until the 22d birthday as long as the beneficiary can establish he is attending high school, college, graduate school, or vocational school on a full-time basis. The committee amendment would eliminate the student benefit for beneficiaries 18 and older who begin post-secondary education after May 1982. For currently enrolled full-time students in post-secondary schools and those who enter post-secondary schools on a full-time basis before May 1982, no benefits would be paid during the 4 summer months, May through August, beginning in 1982. The monthly benefit amount would be reduced by 25 percent beginning in September 1982 and by an equal amount in September 1983, September 1984, and September 1985, with no further student benefits payable to post-secondary students 18 or older after August 1985. No further cost-of-living adjustments would be payable to these students after July 1981. High school students would continue to receive child's benefits as under current law, except that effective in August 1982, no high school student could receive child's benefits after his 19th birthday.

Elimination of the minimum benefit.—Under present law, workers whose average lifetime earnings in covered employment are low are eligible for a "minimum benefit" which is higher than the benefit they would otherwise receive under the benefit computation formula. The 1977 amendments "froze" the minimum benefit at \$122 per month for persons who reach age 62, become disabled, or become eligible for survivor benefits based on the earnings of a worker who dies after 1978. Congressional intent in the 1977 amendments was to gradually phase out the minimum benefit. The committee amendment would eliminate the minimum benefit for all current and future beneficiaries, effective August 1981. Minimum beneficiaries on the rolls as of the effective date would have their benefits recomputed based on the regular benefit formula which underlies the benefit table. Current minimum benefit recipients age 60 to 64, who would be eligible for Supplemental Security Income (SSI) benefits under present law if they were 65, would be permitted to receive SSI payments not to exceed the difference between their newly reduced social security benefit and the amount they had been receiving under prior law. This payment would not be adjusted for changes in the cost-of-living nor would the recipient be entitled to various other benefits such as medicaid or social services.

Restrictions on payment of lump-sum death benefits.—Under present law, a lump-sum death payment (LSDP) of \$255 is payable when a worker who is fully or currently insured dies. If there is a surviving spouse living with the worker at the time of death, the LSDP is automatically paid to that person. If there is no widow or widower eligible to receive the LSDP, the money can be paid to the person or persons who assume responsibility for funeral expenses. If no individual files a claim for the LSDP within 30 days after the death, the funeral home may apply to receive the LSDP directly. The committee amendment would eliminate the LSDP in cases where there is no surviving spouse who had been living with the worker at the time of his death, no spouse eligible for monthly survivor benefits, and no surviving children eligible for survivor benefits.

Recency of work test for disability insurance benefits.—Under present law, in order to be insured for disability insurance benefits, a worker must generally be fully insured and insured for disability (worked during 20 of the 40 quarters immediately prior to the onset of disability or, if under 31, half the quarters elapsed since age 21 but at least 6 quarters). The committee provision would add an additional requirement that the disabled worker must have worked in covered employment during 6 of the 13 quarters immediately preceding the onset of disability. The provision would be effective for persons first becoming disabled 6 months before enactment or later (and coming on the benefit rolls for the first time after the month of enactment).

Modifications of worker's compensation offset provision.—Under current law, a reduction may be made in a worker's disability insurance (DI) benefit, and in benefits for his dependents, for any month during which the worker also receives worker's compensation. This offset applies in the case of a worker under age 62 whose total benefits from DI and worker's compensation combined exceed 80 percent of his "average current earnings" prior to the onset of disability. Average current earnings generally refers to the highest annual amount of covered and non-covered wages earned during the 6-year period consisting of the year the worker becomes disabled and the 5 preceding years. The amount of the reduction in social security benefits is equal to the amount by which total social security benefits plus worker's compensation exceed the higher of two limits: 80 percent of average current earnings or the worker's family's total DI benefits. The reduction begins in the month after the month during which the Social Security Administration (SSA) is notified that a worker is receiving worker's compensation payments. The committee amendment would make three related changes in the offset provision. First, the offset would apply not only to worker's compensation, but also to certain other disability benefits provided under Federal, State, and local programs. Second, the offset would apply to DI benefits paid to workers aged 62 through 64 and their families. Third, the offset would be made beginning with the first month when concurrent receipt of DI and the other public disability benefit begins (rather than the month after SSA is notified). Each provision would be effective for persons first becoming disabled 6 months before enactment or later (and coming on the benefit rolls for the first time after the month of enactment).

Elimination of trust fund financed vocational rehabilitation.—Under current law, a limited amount of disability insurance trust fund money (not to exceed 1.5 percent of total disability benefit costs in the preceding year) can be used to reimburse States for vocational rehabilitation (VR) services provided to disabled beneficiaries. The committee amendment would repeal section 222(d) of the Social Security Act, effective October 1, 1981, thereby eliminating trust fund financing of VR services.

Cost reimbursement for provision of earnings information.—Under current provisions of the Freedom of Information Act and the Privacy Act, the social security trust funds receive only partial reimbursement for the costs of providing earnings information to employers seeking to comply with the record-keeping requirements imposed by the Pension Reform Act of 1974. The committee amendment would require such requestors of earnings information to make full payment to the social security trust funds for expenses incurred, making clear that reimbursement of these costs is not governed by the Freedom of Information Act or by the Privacy Act. Full reimbursement was the practice for such requests in the past.

Modification of rounding rules.—Under current law, at each stage in the computation of benefits (after calculation of the average indexed monthly earnings), the amount derived is rounded up to the next higher 10 cents. The committee amendment would require that amounts be rounded to the nearest penny, except for the final amount—the actual benefit payable to an individual—which would be rounded to the next lower dollar.

Medicare Provisions

Reduction of the 8.5 percent routine nursing salary cost differential.—The bill would reduce the routine nursing salary cost differential to 4.5 percent and requests GAO to conduct a study on the appropriateness of the differential to be completed within 6 months of the enactment of the provision.

Repeal of certain benefit provisions enacted in 1980.—The bill would repeal the following provisions that had been enacted as part of the Omnibus Reconciliation Act of 1980:

Inclusion of need for occupational therapy as a qualifying criterion for home health benefits;

Authority to pay freestanding alcohol detoxification facilities under medicare;

Coverage for hospital stays necessary to carry out dental procedures where they are warranted by the severity of the dental procedure, or the patient's condition;

A provision that permits continuous open enrollment and re-enrollment in medicare part B;

A provision that established a 1 year period beginning January 1, 1981, during which any State which has not already done so could enter into an agreement to buy in to medicare part B coverage for its eligible medicaid recipients;

A provision which provided for a one-time delay of 3 weeks in medicare reimbursement to hospitals under the periodic interim payment procedure.

Repeal of pneumococcal vaccine benefit.—As part of P.L. 96-611, Congress provided medicare coverage for the injection of pneumococcal vaccine. The bill would repeal the medicare provision; a separate section of the bill authorizes medicaid coverage for this service.

Provides authority for the Secretary to impose civil money penalties in cases of medicare and medicaid fraud.—The bill would authorize the Secretary to assess a civil money penalty against any person who he determined, after notice and opportunity for a hearing, has filed a fraudulent claim under the medicare or medicaid program.

Less frequent surveys of skilled nursing facilities.—The bill would permit the Secretary to enter into agreements with skilled nursing facilities for more than 12 months where the SNF has a good record of compliance.

Closure and conversion of underutilized facilities.—The bill would provide for including in short-term hospitals reimbursement, payments for increased operating costs and, in the case of nonprofit institutions, for increased capital costs, associated with the closing down or conversion to approved use of underutilized bed capacity or services.

Criteria for determining reasonable charge for physician services.—The bill would modify existing medicare criteria for determining reasonable charges for physician services. It would require calculation of statewide median charges (in any State with more than one locality) in addition to local prevailing charges. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. The bill would also permit new physicians setting up practices in certain shortage areas to establish their customary charges at the 75th percentile of prevailing charges. The bill would also permit doctors presently practicing in shortage areas to move up to the 75th percentile.

Limitation on reasonable cost and reasonable charge for outpatient services.—The bill would require the Secretary to issue regulations establishing limitations on costs or charges for outpatient services provided by hospitals, community health centers or clinics and by physicians utilizing these facilities. Limits would be based on the reasonableness of these costs in relation to the reasonable charges in the same area for similar services provided in physicians' offices.

Reduction in payment for inappropriate hospital services.—The bill would eliminate the 80 percent occupancy rate exception so that a hospital's payment would be subject to reduction where a medicare or medicaid patient who no longer needs acute hospital services, remains hospitalized, regardless of the occupancy rate of the hospital.

Increase in part B deductible.—The bill would increase the \$60 part B deductible to \$75.

Deletion of carryover provision for the part B deductible.—The bill would exclude medical expenses incurred during the last quarter of the preceding calendar year in determining whether the individual has satisfied the part B deductible in the current calendar year.

Increases in part B premiums.—The bill would provide for maintaining the beneficiary part B premium at the present percent of total program costs.

Coordination of benefits with private coverage for medicare kidney disease patients.—The bill would make medicare a secondary payor for the initial 12-month period of the renal patients medicare eligibility, with medicare reimbursing only its share of those covered costs not covered by the private plan. The provision would apply only where the renal patient is under 65 and not to persons entitled to medicare benefits by reason of age or receipt of disability cash benefits.

Coordination of medicare benefits with FEHBP benefits.—In the case of those individuals who are duly enrolled in medicare and FEHBP the bill would provide for the Federal Employees Health Benefit Plan to be the payor of first resort with medicare paying only those bills not covered by the FEHB plan.

Medicaid Provisions

Cap Federal medicaid expenditures and reduce minimum matching rate.—The bill would place a limit ("cap") on the amount of Federal financial participation in the medicaid program. For fiscal year 1982, Federal expenditures would be allowed to increase 9 percent over the February 1981 State estimates for fiscal year 1981. In subsequent years, Federal spending would be allowed to rise at the rate of inflation as measured by the GNP deflator. To enable States to adjust to the reduced funding level, the bill would provide States with greater flexibility in designing and quickly amending certain eligibility, benefit, and payment provisions of their medicaid plans.

Minimum matching rate.—The bill would lower the minimum Federal matching rate from 50 percent to 40 percent.

Allow accelerated collection of unapproved State medicaid expenditures.—The bill would allow the Federal Government to retain the disallowed medicaid matching funds throughout the appeals process in all cases, including amounts in controversy for past periods. If the appeal is successful, the funds (plus interest) would be returned to the States.

Cost-effective service arrangements.—The bill authorizes the States to establish limits and restrictions with respect to choice by recipients under a Medicaid plan. The bill requires that recipients have reasonable access to services from qualified vendors of health services who meet all applicable standards required by a State's plan.

Reimbursement of hospitals.—The bill would delete the current medicaid provision pertaining to the payment for hospital services on a reasonable cost basis. It substitutes a provision requiring States to reimburse hospitals at rates (determined in accordance with methods and standards developed by the States) that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. The section further requires States to provide assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and periodic audits by the State of such reports.

Services for the medically needy.—The bill removes most of the current requirements for required services for the medically needy giving

greater flexibility to the States. States would be permitted to choose the services to be offered to the medically needy without being bound by requirements pertaining to a minimum number of services or a mix of institutional and noninstitutional services.

Optional coverage for students receiving aid to families with dependent children (AFDC).—The bill amends the definition of "dependent child" under AFDC to persons through age 17, or age 18 if they are completing high school in their 18th year. The bill provides that State Medicaid plans may limit coverage to any person under age 19 who meets the definition of dependent child under AFDC.

Time limitation for waiver request.—The bill would require the Secretary to approve or disapprove a proposed State plan, plan amendment, or waiver request within 90 days after receiving the State request or if later, 90 days after receiving information needed to make a final determination.

Pneumococcal vaccine benefit.—The bill authorizes the Secretary to provide vouchers on a one time basis in FY 1982 to the noninstitutionalized supplemental security income population age 65 and over. In the future, 100 percent Federal matching would be available to States for providing the vaccination to the SSI recipients age 65 and older.

Nonmedical services for certain individuals.—The bill would permit the Secretary to waive the current definition of covered medicaid services to include certain nonmedical support services which are provided pursuant to a plan of care to an individual who is otherwise at risk of being institutionalized and who would, in the absence of such services be institutionalized.

Maternal and Child Health Services Block Grant Provisions

The bill would maintain title V with program modifications and 25 percent reduced funding from the fiscal year 1981 level, as the basis for a separate block grant for health services to mothers and children. The bill consolidates the following programs into the Maternal and Child Health Block Grant: hemophilia, lead-based paint poisoning prevention, genetic disease services, the sudden infant death syndrome (SIDS) program, and the supplemental security income disabled childrens' program.

Unemployment Compensation Provisions

Elimination of the national trigger for the extended benefits program.—Under existing law, up to 13 weeks of benefits over and above the usual maximum duration of 26 weeks for regular State unemployment benefits become payable in times of high unemployment. Fifty percent of the cost of these extended benefits are paid from the proceeds of the Federal unemployment tax. The basis for the extended benefits program is that unemployed workers may reasonably be unable to obtain employment for a longer period of time when jobs are scarce as indicated by high levels of unemployment. Consequently, the law requires States to participate in the extended benefits

program when insured unemployment levels in the State have increased by at least 20 percent (measured against the 2 prior years) and an insured unemployment rate of 4 percent has been reached. Present law also requires, however, that all States implement the extended benefit program when the national insured unemployment rate reaches a level of 4.5 percent. This "national trigger" can result in adding up to 3 months of benefits in a State which has experienced neither a particularly high level of unemployment nor any relative growth in unemployment levels.

The committee amendment would delete the national trigger, effective July 1, 1981.

Exclude extended benefits claimants from State trigger calculation.—Under existing law, the Department of Labor includes extended benefits claimants in the insured unemployed population used to calculate the trigger unemployment rates for the extended benefits program. This means that two States with essentially identical levels of unemployment will have different insured unemployment rates if the extended benefits program is in effect in one State and not in effect in the other.

The committee amendment would exclude extended benefits recipients from the insured unemployed population used to calculate the State trigger insured unemployment rate, effective on the date of enactment.

Modification of optional State trigger level for extended benefits.—Under present law, States are required to participate in the extended unemployment compensation program when the State insured unemployment rate is both at least 4 percent (13-week moving average) and at a level 20 percent higher than the insured unemployment rate in the State during the comparable period in the two preceding years. States which are not participating in the program under the above criteria are nevertheless permitted to participate in it if the State insured unemployment rate is at least 5 percent.

The committee amendment would raise the mandatory State trigger to 5 percent and the optional State trigger to 6 percent, effective the week after September 25, 1982. The "20 percent higher" provision for the mandatory trigger would be retained.

Require 20 weeks of work for extended benefits.—Under present law, to be eligible for unemployment compensation benefits, all States require an individual to have worked for a certain length of time or to have earned a specified amount of wages in the base period. These requirements are designed to test the individual's attachment to the labor force prior to loss of employment, and are intended to assure that only workers with reasonably firm attachment to the labor force qualify for benefits.

The committee amendment would require extended benefits claimants to have worked at least 20 weeks or have its equivalent in wages in the 1-year base period to qualify for benefits, effective for weeks beginning after September 25, 1982. The equivalent in wages could be calculated by the State as either 40 times the claimant's weekly benefit amount or 1.50 times the claimant's wages in the quarter with the highest wages.

Eliminate benefits for those who voluntarily quit military service.—

Under existing law, a servicemember can quit the military and still be eligible for federally financed unemployment compensation benefits. By contrast, every State provides for the disqualification of civilians who voluntarily leave their jobs, are discharged for misconduct, or refuse an offer of suitable work.

The committee amendment would disqualify for unemployment compensation benefits those exservice members who voluntarily leave the service and refuse to re-enlist, effective July 1, 1981.

Loan reform.—Under existing law, the cost of unemployment benefits payable under regular State unemployment compensation programs (and half of the benefit costs arising from the Federal-State extended unemployment compensation program) are funded through payroll taxes imposed by each State. If tax revenues exceed benefit costs, the surplus amounts are retained by the State in an interest bearing account in the Unemployment Trust Fund. If benefit costs exceed revenues, States draw down their accumulated surpluses from prior years. If those surpluses become exhausted, States are allowed to receive an interest-free loan from an account which is funded through the Federal unemployment tax (and is supplemented by borrowing from the general fund of the Treasury). States are generally expected to repay such loans within 2 years. If a State has an outstanding loan at the beginning of 2 consecutive years and fails to make full repayment by November 10 of that year, the Federal Government commences to collect that loan by raising the Federal unemployment tax on employers in the delinquent State. Until the loan is repaid, the Federal tax rate is generally increased by 0.3 percent each year (up to an ultimate maximum tax rate of 3.4 percent of taxable payrolls).

In recent years, several States have made extensive use of these interest-free loans. Some \$6 billion in unpaid loans are now outstanding and in 11 States, employers are subjected to an increased Federal unemployment tax rate. The committee amendment would modify existing loan provisions to level out the increased taxes faced by employers in delinquent States contingent upon a State program meeting certain solvency conditions. The amendment would also make future borrowing subject to interest (except that very short-term borrowing for cash-flow purposes would remain interest free).

Under the committee plan, interest at a rate of 10 percent would be charged on all new advances after May 5, 1981 unless: (1) those advances are repaid by September 30 of the fiscal year in which they were made and (2) the Secretary of Labor certified that the State will be able to meet benefit payments without the need for additional advances for at least 6 months. Interest payments could not be paid from the State unemployment trust fund directly or indirectly (for example, by use of an offsetting State employer tax credit). All repayments of loan principal would first be applied against the principal which had been longest outstanding.

The committee amendment would also provide for a "freeze" on the increased rate of Federal unemployment tax during any year in which a State meets a test of solvency. This test would require that the State engage in no new net borrowing and that it take no action, the net

effect of which represents a relaxation of tax effort or an unfinanced liberalization of benefits. The "freeze" would be set at 0.6 percent or the level of increased tax applicable in the preceding year, whichever is greater. In States where the insured unemployment rate dropped to or below 80 percent of the level in the 2 prior years, an additional 0.3 percent increase in the Federal tax rate would apply. Conversely, in States with high unemployment, as reflected by at least 6 months of extended benefits, the freeze would be available even if the State did require some additional new borrowing. This waiver would be available only to States with State unemployment tax effort at least 50 percent higher than the national average and only for a maximum of 2 consecutive years with repayment of any new borrowing required 2 years after the State no longer qualified for the waiver.

Both the interest provision and the provision freezing increases in the Federal tax in delinquent States would expire on October 1, 1984, unless extended by subsequent legislation.

Aid to Families With Dependent Children (AFDC) Provisions

Limit earned income disregard.—Under current law, in determining AFDC benefits, States are required to disregard from the recipient's total income: (1) The first \$30 earned monthly, plus one-third of additional earnings; and (2) any expenses (including child care) reasonably attributable to the earning of any such income. The work expense disregard is available to both recipients and new applicants. The \$30 and one-third applies only to those already on the rolls and there is no limitation on the length of time these amounts must continue to be disregarded.

After these deductions, whatever income remains is used to reduce the amount of the AFDC grant. The "work-incentive" disregard does not apply to individuals who terminate or refuse employment without good cause, or who fail to report their earnings.

The committee amendment would standardize the work expense disregard at \$75 per month, cap the child care disregard at \$160 per month, and apply the disregards for recipients in the following order:

- (a) The first \$75 of the family's earned income (in lieu of itemized work expenses);
- (b) then, the cost of care for a child or incapacitated adult, up to \$160 per child monthly; and
- (c) finally, \$30, plus one-third of the remainder of earned income (not already disregarded).

As under current law, the \$30 and one-third disregard would not apply if employment has been refused or terminated without good cause, and the work expense and child care disregards would also be denied.

The committee amendment would also allow the \$30 and one-third disregard only during the first 4 consecutive months in which a recipient has earnings in excess of the standard work expense and child care disregards; thereafter, the amount of payment would be determined without benefit of the \$30 and one-third disregard each month that the family continues to receive AFDC and for 12 consecutive months after AFDC is terminated.

Limit allowable resources.—Under current law, the equity value (rather than fair market value) of resources must be considered in determining AFDC eligibility. Regulations establish a maximum of \$2,000 per recipient in real and personal property, including liquid assets, which States may exclude. States may also exclude a home, personal effects, an automobile, and income-producing property.

The committee amendment would place a limit on allowable resources of \$1,000 (equity value) per family, excluding the home and one automobile. The value of the automobile would be limited by regulations.

Permit offset for food stamps and housing subsidies.—Under present law, States may establish the standard to be used in determining AFDC payments. The standard may be "consolidated," that is, provide a dollar amount to cover all basic needs, or it may provide amounts for certain specified items. Federal regulations do not require that a standard of assistance include any specific items or number of items. In setting the dollar amount of the standard, a State may or may not take into account the availability of food stamps. In addition, the State standard may or may not take into account the value of available housing subsidies.

The committee amendment would permit States explicitly to take into account the value of benefits received from food stamps or housing subsidies. This would be done by treating the value of the food stamp coupons or housing subsidy as income, up to the value for food or shelter that is included in the State standard.

Limit eligibility to 150 percent of need standard.—Under current law, there is no limit on the amount of gross income a family may have and still remain on public assistance. As a work incentive for AFDC recipients, the first \$30 plus one-third of the remainder of gross earnings (in addition to work expenses) is disregarded in determining countable income for computing the grant amount.

The committee amendment would limit eligibility for AFDC to families with gross incomes at or below 150 percent of the State's standard of need.

Count lump-sum payments.—Under present law, any payments that meet the definition of income (e.g., retroactive social security benefits) are counted as income in the month of receipt and any of the payment that is not spent in that month is usually considered a resource in the months thereafter.

The committee amendment would require that large payments, together with other income remaining after the application of disregards, be considered available to meet ongoing needs in the AFDC program. If such income exceeds the standard of need, the household would be ineligible for aid. Any amount of the income that exceeds the monthly needs standard would be divided by the monthly needs standard, and the household would be ineligible for aid for the number of months resulting from that calculation. Any remaining amount would be counted as income in the first month following the period of ineligibility.

Assume advance payment of earned income tax credit.—Under present law, the earned income tax credit (EITC) supplements the earn-

ings of the working poor by providing tax credits or rebates through the tax system. Eligible employees may elect to receive their EITC in the form of advance payments added to their paychecks, rather than waiting until the end of the year to apply for refunds. For purposes of determining AFDC eligibility and benefit amounts, the EITC (whether received as an advance payment or an income tax refund) is counted as earned income when actually received.

The committee amendment would provide that in determining earned income for AFDC, the EITC advance payment that the individual is eligible to receive would be included, regardless of whether or not he has applied for the advance payment (i.e., if the individual does not receive advance EITC payments, an amount equal to what he could get as advance payment is imputed as earned income).

Count income of stepparent.—Under existing law, States are prohibited from considering the income of a stepparent, unless, under State law, stepparents are required to support stepchildren to the same extent that natural parents are required to support their children. Income can only be counted in cases in which the welfare agency receives information that money has actually been contributed. States are allowed to prorate AFDC shelter and utility benefits when an eligible child lives with a relative, including a stepparent, who is not an AFDC recipient—as long as the total income exceeds the State's standard of need.

The committee amendment would require the income of a stepparent to be counted in determining eligibility and benefit amounts for AFDC applicants or their children. Countable income would include any amount which exceeds: (1) the first \$75 of earned income (a smaller amount may be prescribed for less than full-time work); (2) the amount specified in the State's standard as the amount needed by the stepparent to support himself and his dependents living in the same household; (3) amounts paid by the stepparent to dependents living outside the household; and (4) payments of alimony or child support to individuals not in the same household. The law would be amended to preclude prorating of shelter allowances with regard to persons to whom this provision applies.

Provisions related to employment of AFDC recipients.—Under existing law, recipients of AFDC are required to register for participation in the Work Incentive (WIN) program unless they fall within certain exempt categories specified in the Federal statute (e.g., mothers caring for children under age 6). Under the WIN program, recipients may be required to accept employment or participate in training. In practice, a substantial part of the AFDC caseload is not served by the WIN program and States are not now allowed to establish alternative work requirements which do not conform closely to the WIN program. The committee approved a series of amendments which would modify this situation so as to provide broad flexibility to experiment with alternative ways of encouraging work effort on the part of persons eligible for AFDC. These amendments are in addition to the existing Work Incentive Program provisions, which remain in force:

a. Community work experience program.—The committee amendment would authorize States to establish community work experience programs for AFDC recipients. Under these programs, recipients

could be required to work on useful public projects in return for their AFDC grants. The amendment requires that the work provided meet appropriate standards with respect to health, safety, and other conditions and that the amount of work required in relation to the family's AFDC payment be consistent with Federal or State wage provisions. Persons exempt under present law from participation in the WIN program would also generally be exempt from participation in this program except that parents caring for children under age 6 (but not under age 3) could be required to participate if child care is available.

b. Providing jobs as an alternative to AFDC.—The committee amendment would also permit States to use savings from reduced AFDC grant levels to make jobs available on an entirely voluntary basis. Under this approach, recipients would be given a choice between taking a job or depending upon a lower AFDC grant than now exists. States implementing this provision could do so in addition to or as an alternative to the community work experience approach.

Under this amendment, States would undertake to use the savings from the reduced AFDC grant levels to provide or underwrite job opportunities for AFDC eligibles. For example, States could pay non-profit and governmental entities a subsidy to cover part of the wage costs of hiring AFDC eligibles. (This type of subsidy would also be available to proprietary as well as nonprofit child day care providers but only if taken in lieu of the tax credit which is otherwise available.) Acceptance of any job offered as a part of this program would be entirely voluntary on the part of the individual involved. (This would not in any way invalidate or suspend work requirements otherwise applicable under Federal or State law as they apply to individuals who receive AFDC.) At State option, medicaid coverage could be continued for participants in subsidized employment under this amendment.

States would have flexibility to implement the amendment for particular areas within the State or for particular categories of recipients and would also have the flexibility to modify the rules for treatment of income so as to avoid situations which would undermine the proposal. For example, modifications might be needed to adjust for offsetting increases in food stamp entitlement or to limit or eliminate the earned income disregard as it applies to those who choose to continue receiving AFDC. (States would not have authority under the proposal to enlarge the disregards otherwise allowable under Federal law.)

If a State elected to utilize this provision, its costs would be contained within the overall level of welfare costs as they would otherwise exist. The total amount of Federal funding for regular AFDC payments and for subsidies provided to employers under the voluntary jobs program could not exceed the present level of estimated AFDC spending in the State (after enactment of the other AFDC changes in the committee bill).

c. Work incentive demonstration projects.—As an additional alternative, the committee amendment would authorize States to implement 3 year demonstration projects of their own design to increase the employment of welfare recipients. Participation criteria would have to follow the Work Incentive (WIN) provisions and would have to be applied statewide. However, the components of the program could

be varied in different regions or political subdivisions of the State. Earnings derived from participating in the project would not make a family ineligible for AFDC.

These demonstration projects would substitute for the regular WIN program, and each participating State would be funded at a level equal to its 1981 WIN allocation augmented by any other Federal funding which may be available for establishing AFDC work programs in the State. (These funds could be used only for operating the work incentive demonstration project and could not be used for direct grants to participating families.) States wishing to utilize this provision would have to submit a proposal within 60 days after enactment. The proposal would automatically be approved unless the Secretary of Health and Human Services notifies a State in writing of his reasons for disapproval within 45 days after the plan is submitted.

Prohibit AFDC payments to strikers.—Presently, Federal law does not expressly exclude strikers from AFDC eligibility. States must pay AFDC benefits to households where the caretaker relative is not required to work but could be working if not involved in a labor dispute (as long as the family meets other eligibility requirements). Where eligibility is based on the unemployed parent, the States have the option of paying or denying benefits to households where the parent's unemployment results from a strike.

The committee amendment would require States to specify that striking workers must comply with all AFDC provisions concerning work registration and training. No AFDC would be payable to a family in which the caretaker relative is engaged in a strike on the last day of the month, and no individual participating in a strike could have his or her needs included in computing the amount of the AFDC grant.

Eliminate AFDC payments to children over 18.—Under present law, the States have the option to define a dependent child to include students age 18 through 20 who are regularly attending primary, secondary, or vocational school, and even college.

The committee would amend the definition of "dependent child" to provide assistance to children through age 17, or 18 if they are completing high school in their 18th year.

Limitation on AFDC to pregnant women.—Under current law, the States have the option of paying AFDC benefits to pregnant women with no other children.

The committee amendment would prohibit AFDC for pregnant women with no other children until the last 3 months of pregnancy. However, AFDC-eligible pregnant women with no children would be covered under medicaid from the determination of pregnancy.

Restrict AFDC eligibility for unemployed parents (AFDC-U).—Under present law, the States have the option to provide AFDC-U benefits to families where both parents are in the home and one is unemployed. Only one parent must be unemployed to meet this eligibility requirement; the other parent may be employed.

The committee amendment would limit AFDC-U eligibility to those families in which the principal earner is unemployed. The principal earner would be the parent who earned more income during

the 2 years preceding the application for benefits. Also, the law would clearly state that the entire family will be ineligible for AFDC if the principal earner is not registered for work or training.

Work requirements for AFDC parents attending college.—Under present law, children 16 and over, including young AFDC parents, are not required to register for work or training under the WIN program if they are attending school (including college) full-time. Also exempt from the WIN registration requirement are those "caretakers" caring for a child under age 6.

The committee amendment would limit the exemption from work requirements to children who are attending, full-time, an elementary, secondary, or vocational school. Also, the exemption for caretakers would be limited to a parent or relative who is personally caring for a child with only brief or infrequent absences from the child.

Require retrospective accounting and monthly reporting.—Under current law, there is no particular accounting period for determining AFDC eligibility and benefits except that a person's income must be considered on a monthly basis. Federal statute also makes no mention of how frequently AFDC recipients must make reports to the welfare agency. Under Federal regulations, however, each State may choose to pay "retrospectively" or "prospectively." "Retrospectively" means paying a recipient after a month has ended—for circumstances that took place during that month. "Prospectively" means paying a recipient during or before a month—based on what the recipient's circumstances are expected to be during that month.

The committee amendment would require States to adopt a system of retrospective accounting along with monthly reporting. Prospective budgeting would be used in the first month after application to prevent hardship and in the final month to prevent payment of benefits to those whose circumstances have changed and who thus no longer meet the needs requirements.

Eliminate payment of less than \$10.—Under present law, States must make a payment to families eligible to receive AFDC regardless of how small the amount of the payment.

The committee amendment would prohibit States from issuing AFDC checks in amounts less than \$10 a month. Individuals denied a benefit as a result of this provision would be considered recipients for all other purposes, including medicaid eligibility.

Remove 20 percent limit on vendor payments.—Under current law, the States are restricted in their use of vendor payments (direct payments by the welfare agency for housing, utilities, etc.). Vendor payments may not be used in more than 20 percent of the State's AFDC caseload. Use of vendor payments is further restricted to those households which are determined to be unable to manage funds properly for the use of the child.

The committee amendment would remove all restrictions on the number of cases in which vendor payments are made by a State, and allow recipients to choose to have vendor payments made even though they could otherwise receive payments directly. There would not have to be a determination that the household cannot manage funds for those who elect to receive vendor payments.

Recover overpayments/pay underpayments.—Currently, Federal law does not address the issue of overpayments and underpayments. By regulation, States are given the option of whether or not to recoup overpayments. However, if States recover overpayments they must also pay underpayments.

The committee amendment would require States to correct overpayments and underpayments in all instances. Recovery of overpayments would be made from current assistance payments, available income and resources, and, for an individual who no longer receives assistance, through the legal process. In any month when overpayments are being recovered, the AFDC payment, together with the recipient's liquid resources and all income, must equal at least 90 percent of the payment a family would receive if there were no disregards from earned income.

Reduced Federal match for training.—Under current law, the Federal Government reimburses States for 75 percent of training expenses for employees (or those preparing for employment) of State or local agencies administering the AFDC program. All other administrative expenses are matched at a 50 percent rate.

The committee amendment would provide that all expenses related to AFDC administration, including training expenses, be matched by the Federal Government at a 50 percent rate.

Child Support Enforcement (CSE) Provisions

Enforce collection of past-due child support and alimony.—Under existing law, the Secretary of Health and Human Services (HHS) is required, upon the request of a State having an approved child support program, to certify to the Secretary of Treasury for collection by the IRS of amounts which represent delinquent child support payments. Collections may be made on behalf of both AFDC and non-AFDC families.

The committee amendment would provide for additional use of the IRS to collect delinquent child support payments. Upon receiving notice from a State child support agency that an individual owes past-due support which has been assigned to the State as a condition of AFDC eligibility, the Secretary of the Treasury would be required to withhold from any tax refunds due that individual, an amount equal to any past-due support. States would be required to reimburse the Federal Government for the cost of the procedure.

Collection of support for adults.—Under current law, a State child support agency is not authorized to collect support (i.e., alimony) on behalf of a parent of a child for whom it is collecting child support. This is the case even when a court has ordered a single amount for both the parent and the child, without specifying the amount payable on behalf of each.

The committee amendment would make State child support agencies responsible for collecting support for a child's parent (with whom the child is living) as well as for the child himself, effective October 1, 1981.

Modify collection fee for non-AFDC families.—Under existing law, States are required to provide services to non-AFDC families request-

ing assistance. States have the option of charging a fee up to \$20 and of retaining a portion of the child support payments to recover costs of administration in excess of the application fee.

The committee amendment would require States to charge a fee equal to 10 percent of the support collected for non-AFDC recipients who use the child support enforcement agency services, effective October 1, 1981. This 10 percent fee would be charged against the absent parent and added to the amount of the collection. The fee would be retained by the State.

Child support obligations not discharged by bankruptcy.—When the Congress enacted the child support legislation in 1974 it included a provision which prohibited the discharge in bankruptcy of a child support obligation which had been assigned to a State as a condition of AFDC eligibility. This Social Security Act provision was subsequently repealed by section 328 of Public Law 95-598 (the 1978 revision of the Bankruptcy Act).

The committee amendment would reinstate the provision previously in effect declaring that a child support obligation assigned to a State as a condition of AFDC eligibility is not discharged in bankruptcy, effective October 1, 1981.

Supplemental Security Income (SSI) Provisions

Retrospective accounting for SSI recipients.—The SSI statute provides for determining a recipient's benefits on the basis of the income anticipated in the calendar quarter. Redeterminations are to be made at such times as provided by the Secretary. There is no provision for regular reporting of changes in income or other factors affecting eligibility.

The committee amendment would provide that SSI eligibility and benefit amount would, in general, be determined on a one-month retrospective basis, rather than a quarterly prospective basis, as under current law. However, for the first month of eligibility (the month in which the application is filed) eligibility and benefit amount would both be determined on a prospective basis.

Elimination of funding of rehabilitation services for SSI recipients.—Under current law, the Secretary of HHS has authority to reimburse State vocational rehabilitation agencies for services to blind and disabled recipients of SSI.

The committee amendment would repeal the authority of the Secretary of HHS to reimburse States for these vocational rehabilitation services, effective October 1, 1981.

Social Services Block Grant Provisions

The committee amendment includes a social services block grant which consolidates the present social services program and certain other programs under the Social Security Act.

Under the committee amendment, the existing portions of the Social Security Act relating to child welfare services (title IV, part B) and foster care and adoption assistance (title IV, part E) would be repealed effective October 1, 1981. The existing title XX social services

grant program would be replaced by a social services block grant that would incorporate the present social services, day care, social service training, foster care, adoption assistance, child welfare services, and child welfare training programs. An estimated \$3.519 billion will be spent on these programs in fiscal year 1981; a total entitlement of \$2.639 billion would be provided for the new social services block grant for fiscal year 1982 and subsequent fiscal years. This figure represents a 25 percent reduction from the amounts available in fiscal year 1981.

There would be no requirement of non-Federal matching funds. Day care offered under the block grant program would be subject to applicable State and local standards but not to Federal standards (States are exempted from Federal standards under present law until July 1981).

A State's share of the \$2.639 billion for the social services block grant would be based on the total amount to which the State was entitled under the various programs listed above as a portion of the total amount to which all States were entitled under these programs as of fiscal year 1981.

A State's share would be reduced by an amount related to foster care, adoption assistance, and child welfare services if the State failed to meet certain requirements related to those services. Specifically, the State would be required to have a child welfare, foster care, and adoption assistance program (as under titles IV-B and IV-E) which includes:

- (1) A services program designed to help children (for whom the State may be required to assume custody) remain, if appropriate, in their homes;

- (2) A system in which, for each child for whose custody the State is responsible, a plan is prepared (and subjected to periodic court or administrative review) that is designed—

- (a) to achieve placement in the least restrictive (most family-like) setting available, or a return to the child's own home, or an adoption placement, as appropriate;

- (b) to ensure that the child receives proper care;

- (c) in the case of a foster care placement, to ensure periodic hearings by a court (or agency approved by the court) to review or determine the placement then in the best interests of the child, and

- (d) to provide services to the parents, child and foster parents in order to improve the conditions in the parent's home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care;

- (3) Adoption assistance for children with special needs;

- (4) Methods for establishing, and periodically reviewing, standards for foster family homes and child care institutions designed to ensure appropriate care;

- (5) A statewide information system, to be implemented by October 1, 1983, from which the status, demographic characteristics, location, and goals for the placement of every child who is in foster care, or who has been in such care within the preceding twelve months, can readily be determined; and

(6) Provision for the expenditure by the State with respect to such child welfare, foster care, and adoption program, for a fiscal year of an amount that is not less than 75 percent of the amount expended by the State, during Fiscal Year 1981 under section 408, and parts B and E of Title IV of the Social Security Act. However, of the total amount allotted to a State under the social services block grant, the proportion for foster care for a fiscal year may not exceed the proportion so expended for Fiscal Year 1981.

A State which does not meet the above requirements would have its social services block grant reduced by 75 percent of the Federal funds for foster care, adoption assistance, and child welfare services that it received in Fiscal Year 1981. State would be given time to phase into full compliance with these requirements in the same manner as under present law.

Under the Committee amendment, the Secretary of Health and Human Services would be directed to conduct a study to identify such criteria and mechanisms as may be useful for the States to assess the effectiveness and efficiency of the service programs under the block grant. The study would include consideration of Federal incentive payments as an option to reward high performance of the States in the services programs. The Secretary would report to the Congress the results of this study within 1 year after the provision is enacted.

Trade Adjustment Assistance Provisions

The committee bill would amend title II, chapter 2 of the Trade Act of 1974 with respect to adjustment assistance for workers by requiring a worker to exhaust all State unemployment insurance (UI) payments before receiving trade readjustment allowance (TRA) payments; by limiting the amount of TRA payments to State UI payment levels; by limiting the duration of TRA and UI payments to most workers to 52 weeks; by requiring increased efforts by beneficiaries to obtain appropriate work; by incorporating certain provisions of State unemployment insurance laws; by changing the trade impact certification standard; by broadening the authority to recover overpayments; and by strengthening the training, job search, and relocation aspects of the program.

Finance Committee Recommendations—Summary Table of Cost Savings

[In millions of dollars]

Provision	FY 1981		FY 1982		FY 1983		FY 1984	
	BA ¹	O ²	BA	O	BA	O	BA	O
<i>Social Security;</i>								
Eliminate student benefits-----	0	0	21	-567	102	-1,580	243	-2,033
Eliminate minimum benefit-----	12	-50	383	-970	487	-1,070	705	-1,070
Restrict payment of lump-sum death benefit-----	1	4-35	9	-200	25	-210	42	-215
Tighten recency of work test for disability benefits-----	0	0	5	-124	22	-350	61	-629
Miscellaneous disability changes-----	0	-5	3	-87	12	-122	23	-156
Discontinue trust fund financing of vocational rehabilitation services-----	0	0	3	-87	10	-86	16	-73
Pension Reform Act—cost reimbursement-----	0	0	0	-1	0	-2	0	-5
Round social security benefits-----	0	-1	3	-74	15	-253	36	-276
Subtotal—Social security-----	13	-91	427	-2,110	673	-3,673	1,126	-4,457
<i>Medicare;</i>								
Reduction in routine nursing differential-----	(*)	-20	5	-130	16	-150	30	-185
Repeal of certain benefit provisions enacted in 1980:								
Occupational therapy-----			1	-35	4	-41	8	-46
Detoxification facilities-----			0	0	0	0	0	0
Inpatient dental coverage-----			(*)	-12	1	-13	3	-16
Open enrollment-----	-1	-1	-9	-9	-10	-10	-11	-11
State buy-in-----			-2	-7	-2	-7	-2	-8
Periodic interim payments-----	-2	4515	(*)	4-522				

See footnotes at end of table.

[In millions of dollars]

Provision	FY 1981		FY 1982		FY 1983		FY 1984	
	BA ¹	O ²	BA	O	BA	O	BA	O
Pneumococcal pneumonia vaccine.....			-44	-44	-24	-24	-24	-24
Civil money penalties.....			-7	-7	-7	-7	-7	-7
Less frequent SNF surveys.....			(*)	-4	(*)	-4	1	-4
Closure and conversion of underutilized facilities.....			(*)	-2	(*)	-7	1	-19
Reasonable charges for physicians' services.....			-13	-13	-21	-21	-25	-25
Limits on costs and charges for outpatient services.....			1	-15	2	-23	4	-27
Inappropriate hospital services exclusion.....	-5	-30	4	-90	11	-100	20	-115
Increase in part B deductible.....			-120	-120	-210	-210	-240	-240
Deletion of part B carryover.....			-55	-55	-55	-55	-55	-55
Increases in part B premiums (offsetting revenues increase) ⁵				-110		-410		-800
Medicare secondary for end-stage renal disease.....			-95	-95	-165	-165	-180	-180
Medicare secondary to Federal employees plans.....			-85	-680	-130	-1,120	-55	-1,110
Offsetting outlays, other agency.....				320		530		520
Authorization level.....			320		530		520	
Subtotal—medicare.....	-8	464	-419	-1,630	-590	-1,837	-532	-2,352
Authorization level.....			320		530		520	

Medicaid:

Cap Federal expenditures, reduce minimum match-----	-1,400	-1,010	-1,770	-1,630	-2,360	-2,230
Accelerated collection of unapproved expenditures-----	-122	-122	(³) 8	(³) 1	(³) 1	(³) 1
Pneumococcal vaccine-----	-122	-122	-1,392	-1,002	-1,769	-1,629
Subtotal—Medicaid-----					-2,359	-2,229

Child and Maternal Health Block Grant:

(Subtotal)-----	-137	-46	-163	-123	-194	-169
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Unemployment Compensation:

Repeal national trigger-----	⁴ -300	⁴ -297	-300	-657	-----	-----
Exclude extended benefit claimants from State trigger calculation-----	-100	-208	-400	-561	-600	-120
Modify State triggers for extended benefits-----					-100	-72
Require 20 weeks of work for extended benefits-----					-11	-10
Eliminate benefits for voluntary military quits-----	-36	-36	-265	-265	-254	-244
Loan reform package (offsetting revenues increase)-----		-10	-----	-207	-----	-405

Subtotal—Unemployment compensation-----	-436	-551	-965	-1,690	-954	-851
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AFDC:

Limit earnings disregard-----			-206	-206	-212	-218
Limit \$30 plus $\frac{1}{2}$ to 4 months-----			-168	-168	-172	-177

See footnotes at end of table.

Provision	FY 1981		FY 1982		FY 1983		FY 1984	
	BA ¹	O ²	BA	O	BA	O	BA	O
Limit allowable resources to \$1,000			-16	-16	-17	-17	-17	-17
Permit offset for food stamps and housing subsidies			-100	-100	-103	-103	-105	-105
Limit eligibility to 150% of State needs			(*)	(*)	(*)	(*)	(*)	(*)
Count lump-sum payments as income			-5	-5	-5	-5	-5	-5
Assume advance payment of EITC			-51	-51	-49	-49	-46	-46
Count stepparents' income			-108	-108	-111	-111	-113	-113
Community work programs			(*)	(*)	-20	-20	-41	-41
Prohibit payments to strikers			-5	-5	-5	-5	-5	-5
Eliminate payments to children over 18			-100	-100	-104	-104	-108	-108
Limit payments to pregnant women			-16	-16	-17	-17	-17	-17
Restrict eligibility for unemployed parent			(*)	(*)	(*)	(*)	(*)	(*)
Work requirements for parents attending college			(*)	(*)	(*)	(*)	(*)	(*)
Require retrospective accounting and monthly reporting			0	0	-187	-187	-195	-195
Eliminate payments of less than \$10			(*)	(*)	(*)	(*)	(*)	(*)
Remove 20% limit on vendor payments			(*)	(*)	(*)	(*)	(*)	(*)
Recover overpayments/pay underpayments			-115	-115	-110	-110	-106	-106
Reduce Federal match for training			-16	-16	-17	-17	-18	-18
Administrative savings			-105	-105	-111	-111	-117	-117
Subtotal—AFDC			-1,011	-1,011	-1,240	-1,240	-1,288	-1,288

Child Support Enforcement:

Enforce collection of child support and alimony	-27	-30	-30	-33
Collection of support for adults	-23	-23	-23	-23
Modify collection fee for non-AFDC cases	-45	-49	-49	-55

Prohibit discharge of child support in bankruptcy.

	-17	-17	-21	-21	-26	-26
Subtotal—OSE.....	-112	-112	-123	-123	-137	-137

Supplemental Security Income:

Retrospective accounting for SSI recipients.....	-30	-30	-60	-60	-60	-60
Eliminate funding of rehabilitation services.....	0	-20	2	-18	5	-15
Authorization level.....	-20	-20	-20	-20	-20	-20

Subtotal—SSI.....	-30	-50	-58	-78	-55	-75
Authorization level.....	-20	-20	-20	-20	-20	-20

Social Services Block Grant:

Subtotal—Social services block grant.....	-993	-993	-1,166	-1,166	-1,319	-1,319
Authorization level.....	-993	-993	-1,166	-1,166	-1,319	-1,319

Trade Adjustment Assistance (subtotal).....	-1,295	-1,295	-800	-800	-450	-450
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Totals:

Outlays and budget authority, direct spending.....	-553	-300	-4,934	-9,939	-5,024	-11,761	-4,233	-13,327
Authorization levels.....	-693	-693	-656	-656	-819	-819	-819	-819
Grand total.....	-553	-300	-5,627	-9,939	-5,680	-11,761	-5,052	-13,327

¹ Budget authority.² Outlays.³ Savings assumed under Medicaid cap.⁴ Original estimate for purpose of reconciliation instruction, as adopted by Budget Committee or amended by Senate. Subsequently re-estimated by Congressional Budget Office. See text.⁵ Traditionally, not treated as technically offsetting receipts by office of Management and Budget.

*Negligible.

II. GENERAL EXPLANATION

A. PROVISIONS RELATED TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (PART A OF TITLE VII)

ELIMINATION OF CHILD'S INSURANCE BENEFITS IN THE CASE OF CHILDREN 18 THROUGH 22 WHO ATTEND POST-SECONDARY SCHOOLS

(Section 701 of the Bill)

Present law.—Monthly cash benefits are paid to the children of an insured worker when the worker retires, becomes disabled, or dies. The amount of the child's benefit is generally equal to 50 percent of the benefit paid to the retired or disabled worker and 75 percent of the worker's benefit in the case of a surviving child. Child beneficiaries generally continue to receive benefits until they marry or reach age 18. Because of a provision enacted in 1965, child's benefits may continue after age 18 and up until the student reaches age 22 as long as the student can establish that he is attending high school, college, graduate school, or vocational school on a full-time basis. Benefits can continue for several months beyond the month the student reaches age 22 (until the end of the school term) if the student has not yet completed his 4-year college degree. This continuation of child's benefits beyond age 18 based on full-time school attendance is what is commonly referred to as the social security "student benefit."

The student beneficiary is not required to show that he is pursuing a degree or that his academic performance has been satisfactory in order to remain eligible for benefits. His benefits may continue during the summer months or during any other period of nonattendance of 4 months or less if he states in advance his intention to return to school immediately after this period or if in fact he does return to school.

Like all social security benefits, student benefits are based on the earnings record of the insured worker and do not take into account the amount of income which may be available to the student from other sources (except insofar as excess earnings under the earnings test may reduce his benefit). Neither does the amount of student benefits payable reflect the actual expenses incurred by the student. About 886,000 students received benefits in 1980. About 80 percent of those students attended post-secondary schools; 20 percent had not yet completed high school.

Committee amendment.—Effective August 1982, the committee amendment would eliminate new benefits for child beneficiaries 18 or older in post-secondary school and 19 or older in high school. However, students 18 or older who began post-secondary school before May 1982 would be able to continue receiving benefits. The amount of their benefits, however, would not be adjusted for changes in the cost-of-living after August 1981. Further, beginning in August 1982, the amount of their benefit would be reduced each year by 25 percent of the August 1981 amount. Benefits would continue until the student turned 22, discontinued his education, or for some other reason ceased to qualify for benefits. (In no case could benefits to a post-secondary student 18 or older continue beyond July 1985.) In addition, beginning in 1982, no benefits would be payable to these post-secondary students

during the summer months, defined as the months May through August.

Under the committee amendment, children under 18 would continue to receive benefits without regard to school attendance, as under present law. A child attending high school full-time could continue to receive benefits beyond his 18th birthday, but only until his 19th birthday. The committee amendment makes no change in the eligibility of disabled children of any age for child's benefits.

Although the committee believes that a child beneficiary's benefits should continue long enough to permit him a reasonable opportunity to complete high school, benefits for post-secondary students 18 and older should be gradually eliminated over the next several years. Federal educational assistance is available for post-secondary students for whom financial assistance is essential to complete their education. (Since the time the student benefit was created in 1965, the amount of such federally funded educational assistance has grown from less than \$300 million to about \$7 billion a year.) State, local, and private resources would also be available to assist these students. Programs whose explicit purpose is to provide financial assistance for education would be able to tailor the amount of aid to the educational and living expenses incurred by the student, and to the financial resources available to the student and his family.

Several recent administrations, including the Reagan administration, have proposed a phase-out of student benefits.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$567
1983.....	1, 580
1984.....	2, 033

These savings estimates do not take account of possible increases in educational assistance expenditures, which are estimated to be approximately \$25 million in 1982, \$40 million in 1983, and \$45 million each year thereafter.

REPEAL OF MINIMUM BENEFIT PROVISION

(Section 702 of the Bill)

Present law.—Social security beneficiaries whose average lifetime earnings in covered employment are low receive a "minimum benefit" which is higher than the benefit they would otherwise receive under the benefit computation formula. Low average earnings can result from many years of work at low wages or from a few years of covered work at relatively high wages. The 1977 amendments "froze" the minimum benefit (or primary insurance amount) at \$122 per month for persons who reach age 62, become disabled, or become eligible for survivor benefits based on the earnings of a worker who dies after 1978. Under the pre-1977 law, the minimum benefit, like all other benefit amounts in the table of benefits, rose with each general benefit increase; \$122 per month was roughly the minimum primary insur-

ance amount in effect in 1978. The new "frozen" minimum used in post-1978 initial benefit computations will not increase in future years, although a beneficiary who receives the frozen minimum benefit amount will be eligible for cost-of-living adjustments after he begins receiving his \$122 benefit.

Not all minimum beneficiaries actually receive \$122 per month. Workers who turned 62, became disabled, or died in 1978 or earlier, and their dependents and survivors receive whatever minimum benefit was in effect at the time they first became eligible for benefits, plus any cost-of-living adjustments awarded since that time. For instance, a 65 year old worker who retired in January 1981 (turned 62 in 1978) would receive a minimum benefit of \$153 per month. In addition, under the "transitional guarantee" rules of the 1977 amendments, workers retiring during a 5-year transition period ending in 1983 may receive a minimum benefit larger than \$122. Finally, some individuals receive benefits which in some cases are more than the primary insurance amount of \$122 and in others are less—i.e., early retirees with actuarially reduced benefits, over age 65 retirees with delayed retirement credits, and dependent spouses, children, and certain other dependents.

Congressional intent in the 1977 amendments was to gradually phase out the minimum benefit. As average earnings levels in the economy tend to rise in the future, fewer and fewer people will have average lifetime earnings in covered work at such low levels that they will qualify only for a benefit as low as the minimum, since the minimum is no longer increasing. (An individual with average annual earnings of \$1,700 will currently qualify for more than the minimum benefit.) About 3 million persons now receive the minimum benefit, including workers, dependents, and survivors.

Committee amendment.—The committee amendment would eliminate the minimum benefit in August 1981 for all present and future beneficiaries. The amount payable to individuals receiving benefits based on the minimum primary insurance amount in August 1981 would be recomputed based on the regular benefit formula. The precise recomputation procedures to be used would be prescribed in regulations issued by the Secretary of Health and Human Services (HHS). All benefits payable to new beneficiaries entering the rolls in August 1981 or later would likewise be based on the regular benefit formula.

The committee believes that the minimum benefit—an amount in excess of what the individual would receive using the regular benefit formula—no longer fulfills the purpose originally intended by Congress. Some minimum beneficiaries, for example, are Federal, State, or local government workers with other government pensions who worked many years in public employment not covered by the social security system. The Social Security Administration (SSA) estimates that perhaps as many as 10 to 12 percent of current minimum beneficiaries also receive public pensions based on noncovered work.

The committee also believes that the minimum benefit is no longer needed since Supplemental Security Income (SSI) is now available for needy aged and disabled people. SSI was established in 1974 to provide a basic level of income support for the needy aged (65 or older), blind, and disabled. According to the administration, about 500,000 minimum beneficiaries already receive SSI. This means that

their SSI benefits, which are currently reduced on account of social security, would increase dollar for dollar to replace any social security benefits lost if the minimum benefit were eliminated. In addition, SSA estimates that another 580,000 persons not now receiving SSI could qualify for benefits if the minimum benefit were eliminated.

In order to prevent a sudden loss of income for needy persons aged 60 to 64 who are presently receiving the minimum benefit but not yet qualified for SSI because of age, the committee amendment would permit such persons to receive an SSI payment not to exceed the difference between the minimum benefit they had been receiving in July 1981 and their newly recomputed social security benefit. In order to receive such an SSI payment, these individuals would have to qualify under all the other rules of the SSI program, including those pertaining to assets and income. SSI payments authorized under the committee amendment would not be adjusted for increases in the cost-of-living; nor would these 60 to 64 year old persons become eligible for certain other benefits including state supplementation, food stamps, medicaid or social services as a result of this amendment. These individuals would become eligible for a full SSI benefit under the regular rules of the SSI program when they turned 65, or became blind or disabled.

In light of the fact that the minimum benefit no longer serves its original purpose, the committee believes that the phase-out enacted in 1977 is too gradual.

Approximately 1.2 million of the 3 million current minimum beneficiaries who would have their benefits recalculated because of this provision, would receive no net reduction in social security benefits. The recalculation of their benefits would result in the same benefit amount or there would be offsetting increases in other social security benefits.

[In millions of dollars; fiscal years]

	1981	1982	1983	1984
Estimated savings:				
Gross savings.....	60	1,300	1,400	1,500
SSI increase.....	10	330	330	430
Net savings.....	50	970	1,070	1,070

RESTRICTIONS ON BENEFICIARIES OF THE LUMP-SUM DEATH PAYMENT

(Section 703 of the Bill)

Present law.—A lump-sum death payment (LSDP) of \$255 is payable when a worker who is fully or currently insured dies. The LSDP was originally designed to return the investment of a worker who died before he received benefits at least equal to the taxes he paid during his working years. It was later restructured to function simply as a death benefit. Although it has been computed since 1950 as three times the worker's primary insurance amount, a statutory maximum of \$255 was enacted in 1954. All lump-sum death payments actually paid since 1974 have been \$255.

If there is a surviving spouse living with the worker at the time of his death, the LSDP is automatically paid to that person. If there is no widow or widower eligible to receive the LSDP, the money can be paid to a relative or other person who assumes responsibility for funeral expenses. The responsible person can request that the payment be made directly to the funeral home. Also, if no individual files a claim for the LSDP within 30 days after the worker's death, the funeral home itself may apply to receive the LSDP directly.

Under present law, the lump-sum death benefit is payable without respect to other benefits that may or may not be payable based on the worker's earnings record. In fiscal year 1978, about 1.3 million lump-sum death payments were made, costing about \$332 million. About 46 percent of LSDP's are made on behalf of unmarried deceased workers who have no survivors eligible to receive monthly cash benefits.

Committee amendment.—The committee amendment would make the lump-sum death benefit payable only in cases where there is a surviving spouse or dependent child eligible to receive it. A surviving spouse living with the worker at the time of his death would automatically receive the LSDP as under current law. If there were no such surviving spouse, the LSDP would be payable to a surviving spouse not living with the worker at the time of his death but eligible for monthly cash benefits based on the worker's earning record. If there were no such surviving spouse, the LSDP could be paid to a young child or disabled child of the deceased worker who was eligible for monthly cash benefits as a surviving child. The amendment would be effective with respect to deaths occurring after July 1981.

The committee believes this modification of the lump-sum death benefit would insure that LSDP's are paid only to persons who are actually dependent on the worker's earnings for support prior to his death.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$35
1982.....	200
1983.....	210
1984.....	215

RECENCY OF WORK TEST FOR DISABILITY BENEFITS

(Section 704 of the Bill)

Present law.—In order to be eligible for disability insurance benefits, a worker must not only be determined to be disabled, but also must meet certain insured status requirements. To be insured for disability benefits, a worker must generally be both "fully insured" (generally, one quarter of coverage for each year since 1950 or for each year since the worker reached age 21, up to the year before the onset of disability) and "insured for disability" (worked during 20 of the 40 quarters immediately preceding the onset of disability or, if under 31, half the quarters elapsed since age 21 but at least 6 quarters). This means that a worker generally retains insured status for disability benefits for up to 5 years after leaving covered employment.

Committee amendment.—In addition to the insured status requirements already a part of present law, the committee amendment would require workers first becoming disabled 6 months before enactment or later (and coming on the benefit rolls for the first time after the month of enactment) to have worked in covered employment during 6 of the 13 calendar quarters immediately preceding the onset of disability. This recency of work test was part of the original disability insurance law enacted in 1956, but was repealed 2 years later.

The committee sees this amendment as a means of strengthening the link between loss of earnings due to a disabling condition and replacement of those earnings through monthly cash benefits. In other words, if the worker has not actually been working in covered employment for several years, he was not depending on those earnings for basic income support at the time he became disabled. Therefore, the committee believes it is unreasonable to argue that those earnings should be partially replaced by monthly social security benefits for him and his family.

Estimated savings.—

Fiscal year:	Millions
1981.....	.....
1982.....	\$124
1983.....	350
1984.....	629

REDUCTION IN DISABILITY BENEFITS ON ACCOUNT OF OTHER RELATED PAYMENTS; EXTENSION OF OFFSET TO DISABLED WORKER BENEFICIARIES AGED 62 THROUGH 64 AND THEIR FAMILIES; CHANGE IN MONTH IN WHICH PAYMENTS ARE OFFSET

(Section 705 of the Bill)

Present law.—Under current law, a reduction is made in a worker's disability insurance (DI) benefits, and in benefits to his dependents, for any month during which the worker also receives worker's compensation. This offset, or reduction in DI to take account of worker's compensation, applies only when the worker is under 62 and if the total benefits payable to the worker or family exceed 80 percent of his "average current earnings" prior to the onset of disability. Average current earnings generally means the highest annual amount of covered and noncovered wages earned during the 6-year period consisting of the year the worker became disabled and the 5 preceding years. The offset is not made if the State worker's compensation law provides for an offset against social security benefits.

The amount of the reduction in social security benefits is equal to the amount by which total social security benefits plus worker's compensation exceeds the higher of two limits: 80 percent of average current earnings, or the worker's or family's total DI benefits. The combined payments after the reduction are never less than the total amount of the DI benefits payable before the reduction. The offset begins in the month after the Social Security Administration (SSA) is notified that a worker is entitled to a worker's compensation payment under a Federal or State law.

Committee amendment.—The committee amendment would make three modifications of the present worker's compensation offset. All three changes would affect workers first becoming disabled 6 months before enactment or later (and coming on the benefit rolls for the first time after the month of enactment). First, the offset provision would be expanded to include other disability benefits provided by Federal, State, and local governments, except that needs-tested benefits, Veterans Administration disability benefits, and benefits based on public employment covered by social security would not be taken into account. Private insurance benefits also would not be included in the offset. The amount of the reduction would be calculated as under the present worker's compensation offset provision. The committee believes this amendment is needed in order to eliminate duplicate benefits which overcompensate some disabled workers, discouraging them from attempting to return to work, and creating unnecessary Government expenditures.

Second, the reduction in DI to take account of disability benefits provided under other Government programs would apply not only to workers under 62 and their families, but also to workers 62 through 64 and their families. The committee does not believe that workers 62 through 64 should be treated differently under this provision than workers under 62.

Third, the reduction would be made not in the month following the month in which SSA is notified of the concurrent payment of the two public disability benefits, but beginning with the month during which the concurrent payment actually began. This change would allow the duplicative benefit situation to be corrected more promptly, resulting in trust fund savings and reduced incentives for the disabled worker to delay reporting the receipt of other disability benefits to the SSA.

The committee recognizes that proper implementation of this amendment would require effective exchanges of information between the Social Security Administration and other agencies or organizations paying benefits based on disability. The bill specifically calls for such exchanges of information among the Federal agencies involved, regardless of any other laws that may be designed to protect the privacy of information concerning individual benefit rights or related information necessary to the administration of this provision. For a number of legal and technical reasons, the bill does not similarly require the exchange of such information between the Social Security Administration and non-Federal agencies or organizations which administer plans paying benefits based on disability; however, the committee recognizes that similar exchanges of information in these cases would be essential to the operation of this provision. The committee intends that such cooperation and exchange of information as the Secretary finds necessary shall occur and anticipates that States will be willing to make any necessary modifications of existing laws or regulations otherwise limiting the disclosure of the necessary information.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$5
1982.....	87
1983.....	122
1984.....	156

**ELIMINATION OF USE OF TRUST FUNDS TO PAY FOR VOCATIONAL
REHABILITATION SERVICES FOR DISABLED BENEFICIARIES**

(Section 706 of the Bill)

Present law.—Since 1965, some social security trust fund money has been used to reimburse States for vocational rehabilitation services provided to disabled beneficiaries. Present law limits the amount of trust fund money used for this purpose in any year to not more than 1.5 percent of the total cost of benefits for disabled beneficiaries in the preceding year. In fiscal year 1980, 96,000 beneficiaries received rehabilitation services, at a total cost to the trust fund of \$113 million. This year, the level of funding for these services has been sharply reduced through administrative action.

Committee amendment.—The committee amendment would repeal Section 222(d) of the Social Security Act, effective October 1, 1981, eliminating trust fund support for vocational rehabilitation. States would be permitted to use a portion of the proposed social services block grant funds for this purpose if they chose to do so. This amendment would remove a services function from the earnings-related cash benefits program.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$87
1983.....	86
1984.....	73

PENSION REFORM ACT; COST REIMBURSEMENT

(Section 707 of the Bill)

Present law.—Provisions of the Pension Reform Act of 1974 require administrators of most employee pension plans to furnish plan participants with information concerning their accrued and vested benefit rights. In addition, employers are required to maintain records, in accordance with Department of Labor regulations, sufficient to determine the benefits which are or may become due to each employee. While some pension plans have not kept the necessary earnings information, SSA does maintain this information. It is not always readily accessible, however, thus sometimes requiring a manual search. SSA has already received requests from plans for complete earnings histories of plan members and estimates that there will be requests for about 300,000 earnings histories during the next 5 years. Under the provisions of the Freedom of Information Act and the Privacy Act, the cost of retrieving and transmitting this information is not fully borne by the requestor. Part is financed by the social security trust funds. Prior to these Acts, SSA was receiving full cost reimbursement for these requests.

Committee amendment.—The committee amendment would make clear that the reimbursement for costs incurred in providing earnings information to employers who seek to comply with the Pension Reform Act would not be governed by the Freedom of Information Act or by the Privacy Act. The effect of this amendment would be to permit

SSA to receive full reimbursement for these costs. This change would have no effect on individual beneficiaries, who could continue to receive, free of charge, copies of records of their own earnings.

Estimated savings.—

Fiscal year:	Millions
1981.....	—
1982.....	\$1
1983.....	2
1984.....	5

ROUNDING OF BENEFITS

(Section 708 of the Bill)

Present law.—At each stage in the computation of benefits (after calculation of a worker's average indexed monthly earnings), the amount derived is rounded up to the next higher ten cents.

Committee amendment.—Under the committee amendment, at each stage in the benefit computation (after calculation of a worker's average indexed monthly earnings), the amount derived would be rounded to the nearest penny, except in the last step—computation of the final benefit amount payable—which would be rounded down to the next lower dollar after deduction of the supplementary medical insurance premium. The new rounding rules would not apply to benefits for months prior to July 1981.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$1
1982.....	74
1983.....	253
1984.....	276

B. PROVISIONS RELATED TO MEDICARE

REDUCTION OF THE 8.5 PERCENT ROUTINE NURSING SALARY COST
DIFFERENTIAL

(Section 711 of the Bill)

Present law.—Under present law, medicare reimburses hospitals on the basis of their "reasonable costs." Since July 1, 1969, the Secretary has by regulation paid an 8.5-percent plus factor for inpatient routine nursing salary costs on the theory that older patients require more nursing care than the average patient. There was no objective, convincing evidence in 1969, that this plus factor was warranted. Moreover, in the years since 1969, there have been changes in medicare law, changes in the way services are furnished, and changes in the way medicare reimburses for routine services that make the cost differential even less tenable today than when it was adopted. For example, the inclusion in 1972 in medicare of disabled beneficiaries who are below age 65 has made an average routine per diem amount for all beneficiaries (without recognition of any differential) more ap-

propriate. Also, with the growth of special-care beds (intensive care, coronary care, etc.), there has been a shift of the intensely ill from general routine-care areas to these special-care units. It has been noted that since intensive nursing care is now being given in these special-care units, the nursing cost differential for routine services may have become less necessary than in the past. However, despite these considerations, many institutions have stated that a differential is still justified.

Committee amendment.—The bill provides for a reduction in the routine nursing salary cost differential to 4.5 percent beginning with the date of enactment. The bill further requests the Comptroller General to conduct a study to determine the extent (if any) to which the reasonable cost of efficiently providing routine inpatient nursing services to medicare patients exceeds the average cost of providing such services to other individuals. The committee intends to reconsider the appropriateness of a nursing differential following completion of the study.

A similar provision for a Comptroller General study was included in the Senate version of the Reconciliation Act of 1980, which passed the Senate on June 30, 1980.

On July 16, 1980, the Comptroller General advised the committee that a study of the routine nursing costs which are attributable to the elderly could not be undertaken without additional financial resources—specifically funds to contract for temporary nursing personnel to make the work sampling observations at the study hospitals—which would cost about \$4 million.

Although the provision for the GAO study was dropped during the House-Senate conference on the 1980 Reconciliation Act, the committee has been informed by the GAO that it had proceeded to develop a work sampling methodology for the study and had tested it at one hospital. This experience has confirmed the earlier conclusion by GAO that the use of trained nurses to make the observations in the hospitals, though quite costly, is the only feasible approach to accurately and reliably collect the data, avoid disruption to hospital routines, and provide the patient privacy necessary for hospital and patient cooperation. Therefore, to assure the successful conduct of the study, it will be necessary to appropriate supplemental funds specifically for the purpose of obtaining the required contract assistance.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$20
1982.....	130
1983.....	150
1984.....	185

REPEAL OF CERTAIN BENEFIT PROVISIONS ENACTED IN 1980

(Sections 712-717 of the Bill)

Present law.—The “Omnibus Reconciliation Act of 1980” (P.L. 96-499) included a number of benefit expansions in the medicare program.

1. In order to qualify for home health benefits under current law, a beneficiary must require skilled nursing care, speech therapy, or physical therapy. Once a beneficiary qualifies for home health benefits, certain other services such as occupational therapy are covered. P.L. 96-499 included, effective July 1, 1981, a need for occupational therapy as a qualifying criterion for home health benefits.

2. P.L. 96-499 authorized payment under medicare part A for inpatient detoxification services provided in a freestanding facility. Under the provision, payment would be made to the facility on a reasonable cost basis with no deductibles or coinsurance required. The provision became effective April 1, 1981. P.L. 96-499 also required the Secretary to conduct a study on the appropriateness of extending coverage to drug detoxification, post-detoxification rehabilitation, and outpatient detoxification and on incentives for use of lower-cost detoxification facilities.

3. Current law provides coverage for hospitalization in conjunction with a noncovered dental procedure where warranted by an underlying medical condition P.L. 96-499 authorized, effective, July 1, 1981, hospitalization coverage under medicare where the severity of the noncovered dental procedure warrants inpatient care.

4. Under prior law, beneficiaries who failed to enroll when initially eligible for medicare could do so only during an annual open enrollment period (January-March of each year). Reenrollment was permitted only once. P.L. 96-499 provided, effective April 1, 1981, for continuous open enrollment and unlimited reenrollment.

5. By law, States can buy Medicare Part B protection (i.e., pay the premium amounts) on behalf of their medicaid eligibles who are also eligible for medicare. States were required to enter such "buy-in" agreements with the Secretary by January 1, 1970. P.L. 96-499 permitted States to enter into or modify such agreements during calendar year 1981.

6. Under current reimbursement arrangements hospitals may receive periodic interim payments (PIP) from medicare which are not directly tied to the receipt of bills. In order to provide for a reduction in fiscal year 1981 expenditures, P.L. 96-499 amended the PIP procedure for hospitals to provide for a one-time deferral during the last month of fiscal year 1981 of amounts equal to 3 weeks of medicare payments. Hospitals would receive the deferred payments early in fiscal year 1982. The committee notes that the provisions would have resulted in a net increase in program costs since increased interest expenses incurred by hospitals that borrow to compensate for the brief interruption in their cash-flow would have been reimbursable.

Committee amendment.—The committee would repeal each of the provisions noted above with one exception.

In the case of the amendment which would have provided for continuous open enrollment and reenrollment, the committee would repeal only that provision which provides for continuous open enrollment. The repeal would be effective on the date of enactment of this bill. The committee intends that any individual who enrolled under Part B when the provisions of the Omnibus Reconciliation Act were in effect shall not have this enrollment subsequently denied.

Estimated savings.—

Fiscal year:

	Millions
1981.....	¹ \$514
1982.....	585
1983.....	71
1984.....	81

¹ Net additional expenditures in 1981.

PNEUMOCOCCAL VACCINE

(Section 718 of the Bill)

Present law.—P.L. 96-611 authorized medicare part B coverage beginning July 1, 1981, for pneumococcal vaccine and its administration. The legislation provided that payment for these services would equal 100 percent of the reasonable charge and not be subject to the deductible or coinsurance requirements. Payment could only be made when the service was reasonable and necessary for the prevention of illness.

Committee amendments.—The bill repeals the provision of P.L. 96-611. Section 29 modifies the medicaid program to authorize Federal assistance for pneumococcal vaccine for persons least able to purchase such services on their own.

Estimated savings.—

Fiscal year:

	Millions
1981.....	
1982.....	\$44
1983.....	24
1984.....	24

AUTHORITY FOR THE SECRETARY TO IMPOSE CIVIL MONEY PENALTIES IN
CASES OF MEDICARE AND MEDICAID FRAUD

(Section 719 of the Bill)

Present law.—Current law establishes criminal penalties for persons convicted of committing specified fraudulent acts under medicare and medicaid. Fraudulent activities include: filing of false claims; misrepresentation of qualifications of an institution in order that the institution can qualify as a provider; and solicitation, receipt or offering of kickbacks, bribes, or rebates. Such acts are punishable by a maximum fine of \$25,000, 5 years imprisonment, or both. Current law also requires the Secretary to suspend from medicare any practitioner convicted of a criminal offense and any institutional provider in which a managing employee has been so convicted and to require the State medicaid agency to suspend the physician or provider from the medicaid program. The law also allows the Secretary to exclude from medicare individual practitioners or providers that knowingly or willfully make or cause to be made any false statements in an application for payment, or submit excessive bills, or furnish services in excess of need.

Cases of potential fraud which are deemed appropriate for prosecution are forwarded by the Department of Health and Human Services to the Department of Justice. However, many of the cases are not brought to trial. U.S. attorneys may refuse to accept medicare and medicaid fraud cases for any number of reasons: e.g., the U.S. attorney has a backlog of cases; or he may lack sufficient expertise in medicare-medicad law to prosecute and may feel the investment of time and effort to acquire the expertise is not warranted; or the number of counts or amount of money involved may not be sufficient in his judgment to warrant criminal court proceedings. None of these examples imply the nonexistence of fraud or lack of culpability on the part of the alleged offender; they only indicate the U.S. attorney's unwillingness to accept many cases because they appear to be unsuitable for prosecution.

Under present law, when a decision is made not to accept a case for prosecution the only recourse for the Government is to attempt recovery of the overpayment involved. But even if such recovery is successful, the offender has had penalty-free use of Federal funds for a period of time.

Currently, eleven executive departments and sixteen independent agencies have the power to impose civil penalties, either through administrative imposition or court imposition (assessment by a court upon application of the agency or U.S. attorney). Under the civil money penalty provisions for nine of these agencies, assessment authority lies with the agency itself.

Committee amendment.—The bill authorizes the Secretary of HHS to assess a civil monetary penalty of up to \$2,000 per claim against any person who he determines has filed a fraudulent claim under the medicare or medicaid programs. It also authorizes the Secretary to impose an assessment, in addition to the penalty, of up to twice the amount of the fraudulent portion of the claim in lieu of damages. Persons subject to a penalty would be given written notice and an opportunity for a hearing on the record prior to imposition of a penalty.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$7
1983.....	7
1984.....	7

LESS FREQUENT SURVEYS OF SKILLED NURSING FACILITIES

(Section 720 of the Bill)

Present law.—Under current medicare law, provider agreements with skilled nursing facilities, unlike those with hospitals, are required by law to be renewed every 12 months; under certain circumstances an additional 2-month period is allowed. In order to renew an agreement with medicare, a skilled nursing facility must undergo a survey to confirm its compliance with applicable health and safety requirements. While the Secretary has the authority to reduce the frequency of provider agreements for other participating institutions, he does

not have similar flexibility with respect to skilled nursing facilities.

Committee amendment.—Upon enactment, the bill would permit the Secretary to enter into agreements with skilled nursing facilities for periods in excess of 12 months, thus removing the necessity for an annual survey. It is expected that less frequent surveys would be permitted only in cases where the facility had demonstrated consistent compliance with medicare conditions of participation. The committee intends that annual surveys would continue for facilities with significant deficiencies or a history of noncompliance with medicare conditions of participation.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$4
1983.....	4
1984.....	4

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED
FACILITIES

(Section 720A of the Bill)

Background.—Studies have pointed to a national surplus of short-term general hospital beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered by the hospital. In addition there are the continuing expenses associated with maintenance, and staffing involved in keeping an empty bed ready for use. Surplus beds contribute to cost escalation in other less obvious ways. Unnecessary or underutilized hospital facilities can drain scarce manpower and generate scarcities of trained personnel, which in turn drive up salaries and may even threaten the quality of care. Coupled with the availability of hospitalization insurance, bed surpluses tend to generate pressures to use high cost hospital beds rather than less expensive alternative forms of care. Additionally, the development of alternatives to inpatient facilities, such as primary care and community home care programs, suffers when investment is needlessly diverted to underutilized hospital bed capacity.

Committee amendment.—The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals. A hospital could apply for such payments *before or after* the conversion or closing takes place. In the case of for-profit short-term hospitals, reimbursement would be limited to increased operating costs. This would include: costs which might not be otherwise reimbursable because of payment “ceilings”; and severance pay, “moth-balling” and related expenses. In addition, payments could be continued for reasonable capital costs in the form of depreciation allowances, or reimbursement for interest payments which would ordinarily be applied toward payment of outstanding debt which had been incurred in connection with the terminated beds. In the case of a

complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

The Secretary would establish a Hospital Transitional Allowance Board which would consider requests for such payments. Appropriate safeguards would be developed to forestall any abuse or speculation. Prior to January 1, 1984, not more than 50 hospitals could be paid a transitional allowance in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering severe financial penalty. The Secretary is required to report to the Congress, on or before January 1, 1983, an evaluation of the effectiveness of the program and any recommendations.

The committee recognizes that a facility which is generally underutilized, and which would therefore be potentially eligible for a transitional allowance to finance a facility conversion, may be the sole or primary source of care for needed health services in the community. It is the intent of this committee that the availability of a transitional allowance not encourage the conversion of a facility that is needed in the community. Therefore, it will be necessary for the Hospital Transitional Allowance Board to determine that the facility conversion will not have an adverse impact on access to needed health care services before the Board may recommend that the Secretary establish a transitional allowance for the hospital. Only in those cases in which reasonable access to needed health care services will not be jeopardized may a transitional allowance be recommended.

Estimated Savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$2
1983.....	7
1984.....	19

CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

(Section 720B of the Bill)

Present law.—Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable charges." For example, one State has 28 different localities. The committee notes that this has led in many instances to unjustified disparities among areas of the same State. Additionally, under present law, increases in prevailing charges are limited to levels justified by changes in the costs of practice and wage levels. The committee is concerned that the effect of present law is to further widen the dollar gap between prevailing charges in different localities.

Committee amendment.—The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher

than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Under existing policy, the allowable "customary charge" for a new physician may not exceed the 50th percentile of charges in the locality. The bill would permit new physicians in localities which are designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of the local charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit established physicians in these shortage areas to move up to the 75th percentile on the basis of their actual fee levels. In designating physicians shortage areas the bill would require the Secretary to apply the same criteria as is utilized in determining whether rural health clinics are eligible to participate in medicare.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$13
1983.....	21
1984.....	25

LIMITATION ON REASONABLE COST AND REASONABLE CHARGE FOR
OUTPATIENT SERVICES

(Section 720C of the Bill)

Background.—As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have a disproportionately large share of their total costs financed by the revenues from their outpatient departments. In addition, reimbursement to community health centers and similar free-standing clinics which are presently paid on a cost-related basis, have, according to the General Accounting Office sometimes proved to be excessive.

Committee amendment.—The bill requires the Secretary to issue regulations establishing limitations on costs or charges for outpatient services provided by hospitals, community health centers or clinics and by physicians utilizing these facilities. Limits would be required to be reasonably related to the reasonable charges in the same area for similar services provided in a physicians office. It is the desire of the committee that we begin to equalize the reimbursement for similar services which are provided in differing ambulatory settings, thus removing any incentive to provide services at any one particular location.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$15
1983.....	23
1984.....	27

REDUCTION IN PAYMENT FOR INAPPROPRIATE HOSPITAL SERVICES

(Section 20D of the Bill)

Present law.—The “Omnibus Reconciliation Act of 1980” (P.L. 96-499) added requirements to medicare and medicaid pertaining to payment for inappropriate hospital services. The legislation provided that where a beneficiary no longer requires acute hospital services but must remain in the hospital because a medically necessary long-term bed is not available in the community, the hospital will be reimbursed at a daily rate equal to the estimated average medicaid skilled nursing facility (SNF) or intermediate care facility (ICF) rate, whichever is appropriate. The reduced level of reimbursement would not apply where a hospital’s annual occupancy rate is equal to or greater than 80 percent. In determining the occupancy rates of public hospitals under common ownership, where patients can be transferred among the related institutions, the occupancy rates can (with the approval of the Secretary) be calculated on an aggregate basis in determining whether the 80-percent test is satisfied. The provision is to become effective on the date final implementing regulations are issued, which was to be no later than June 1, 1981. Two years after enactment, the computation of occupancy rates is to be adjusted, to the extent feasible, to exclude from the computation those long-term care patients who should not be in the hospital.

The purpose of this provision was to tailor Federal and State payments for the patients in question to fit more closely the level of services that long term patients in hospitals actually receive. The provision was also intended to encourage the conversion of excess acute care beds to needed long-term care beds where appropriate.

Committee amendment.—Effective upon enactment, the bill eliminates the 80-percent occupancy rate exception. Under the bill, a hospital’s payments would be reduced by medicare if there is an excess of beds in the institution in which the patient is hospitalized, or an excess of hospital beds in the area, which could presumably be converted to long-term care use. In such cases, medicaid could pay no more than the reduced amount.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$30
1982.....	90
1983.....	100
1984.....	115

INCREASE IN THE PART B DEDUCTIBLE

(Section 720E of the Bill)

Present law.—Under the Supplementary Medical Insurance Program (part B), medicare beneficiaries are required (with certain exceptions) to incur \$60 in expenses for covered medical services before the program will begin making payments. The deductible is not applicable with respect to radiologist and pathologist services furnished to hospital inpatients. (Effective July 1, 1981, this exception will only

apply in cases where the physician accepts assignments for all such services.) The deductible will also not apply with respect to certain surgical procedures performed on an ambulatory basis, provided certain conditions are met. Effective July 1, 1981, the deductible requirements will be removed for home health services reimbursed under part B.

Committee amendment.—The part B deductible is fixed by law and has been increased only once since the inception of the program. The “Social Security Amendments of 1972” (Public Law 92-603) raised the deductible, effective calendar year 1973, from \$50 to \$60. In view of the large increase in medical costs and program expenditures which has occurred since 1973, the committee feels it is appropriate to provide for a modest increase in the deductible. The bill therefore raises the part B deductible to \$75 beginning in calendar year 1982.

Estimated savings.—

Fiscal year:	Millions
1981.....	.....
1982.....	\$120
1983.....	210
1984.....	240

DELETION OF CARRYOVER PROVISION FOR THE PART B DEDUCTIBLE

(Section 720F of the Bill)

Present law.—Under the Supplementary Medical Insurance Program (part B), medicare beneficiaries are required to incur \$60 annually in expenses for most covered medical services before the program will begin making payments. Section 20E of the bill raises this deductible amount to \$75 beginning in calendar year 1982. In determining whether an individual has met the deductible, unreimbursed expenses incurred in the current calendar year plus those incurred in the last 3 months of the preceding calendar year are considered.

Committee amendment.—Effective with expenses incurred on or after October 1, 1981, the bill excludes medical expenses incurred during the last quarter of the preceding calendar year in determining whether the individual has satisfied the part B deductible in the current calendar year.

Estimated savings.—

Fiscal year:	Millions
1981.....	.....
1982.....	\$55
1983.....	55
1984.....	55

INCREASE IN PART B PREMIUMS

(Section 720G of the Bill)

Present law.—Individuals who elect to be covered under the Supplementary Medical Insurance Program (part B), are required to pay a monthly premium. The amount of the premium is currently \$9.60; it is slated to rise to \$11.00 in July 1981.

Prior to July 1973, the Secretary annually determined the premium rate by estimating the amount necessary to meet one-half of the benefits and administrative costs payable from the part B trust fund for the applicable 12-month period, plus a contingency reserve. The Federal Government appropriated out of general revenues a contribution equal to the total of the premiums paid by the elderly to finance the remaining half of the Supplementary Medical Insurance program's costs.

The "Social Security Amendments of 1972" (Public Law 92-603) and subsequent amendments modified the method by which premiums were calculated to limit increases in premium amounts to the percentage by which monthly cash benefits increased in the interval since the premium was last increased. Under current law the Secretary is required to calculate each December the premium amount for the aged, to be effective the following July the new premium rate is the lower of: (a) the actuarial amount sufficient to cover one-half of the benefits to be effective the following July. The new premium rate is the lower for the aged plus administrative costs, and a contingency amount; or (b) the current premium amount increased by the percentage by which social security cash benefits will increase the following May over the amount in effect in May of the current year. The premium rate calculated for the aged is also paid by disability beneficiaries, who are under age 65, even though they have higher health costs than the elderly.

In announcing the rate to be effective July 1, 1981, the Secretary specified that the amount which would be sufficient to cover one-half of the part B costs of the aged is \$22.60 (\$36.60 for the disabled). However, because premium increases have been limited to the percentage by which social security cash benefits have increased, the premium amount actually promulgated for the period is \$11.00. Therefore for the period beginning July 1, 1981, beneficiary premium contributions will be equal to 24.3 percent of anticipated part B costs for the aged and 15.0 percent of such costs for the disabled.

Committee amendment.—The committee notes that under current law beneficiary premium contributions when measured as a percentage of total part B costs, can be expected to continue to decline. Effective July 1, 1982, the bill provides for maintaining the beneficiary part B premium at 24 percent of total program costs. Only costs attributable to services provided to the aged will be used in making this determination. The calculation will be based on estimates for the part B program as reported by the Secretary each December, beginning December 1981. For the period beginning July 1, 1982 and subsequent 1-year periods the part B premium paid by the aged will represent approximately the same percentage of medicare expenditures for aged medicare beneficiaries as the rate promulgated for the 1-year period beginning July 1, 1981. As in the past, the premium amount calculated for the aged will also be applicable to the disabled.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$110
1983.....	410
1984.....	800

MEDICARE PAYMENTS SECONDARY IN CASES OF END-STAGE RENAL DISEASE

(Section 720H of the Bill)

Present law.—Under present law, individuals eligible for medicare coverage because of kidney failure qualify for protection beginning with the first day of the third month after the month in which dialysis is initiated. Those who require kidney transplantation are covered beginning in the month in which the individual is hospitalized for the transplantation procedure. When an individual becomes eligible for medicare in such instances, medicare benefits are immediately payable without regard to any other health insurance coverage the individual may have—i.e., medicare is the primary payor of benefits for end-stage renal patients.

Committee amendment.—Today many private health insurance plans provide very comprehensive health benefit protection, including protection against catastrophic health expenses. However, in the case of end-stage renal patients, such plans now pay little, if anything, toward the costs of kidney dialysis treatments or organ transplantation. This is because most health plans (and particularly group plans that cover workers and their dependents) contain provisions that are intended to prevent payment of benefits where the insured is also entitled to benefits as a result of coverage under a program such as medicare. The private plans may pay a reduced amount of benefits which, when added to any benefits paid by another plan, will not exceed 100 percent of the actual expenses incurred by the insured. However, since medicare pays first and provides very comprehensive benefits for those with end-stage renal disease, private plans pay little of the expenses incurred by most end-stage renal patients.

The bill changes the benefit coordination arrangements between the medicare end-stage renal program and any other health benefits to which an individual may be entitled by making any private coverage primary to medicare for an initial 12 months after the beneficiary is determined eligible for medicare coverage under the end-stage renal provisions of the law. During this period, medicare would not reimburse any expense to the extent that payment is made, or can reasonably be expected to be made (as determined by regulation), by any private health plan or policy of insurance. Medicare would become the primary payor (i.e., pay benefits without regard to any other coverage) beginning with the thirteenth month following the month in which entitlement to medicare end-stage renal benefits was established. This coordination provision would apply only in instances of patients entitled to benefits under the medicare renal program who are under age 65 and who are not in receipt of disability cash benefits.

In the event payment by a private plan or policy is less than any amount charged for a covered item or service, medicare (in its role as secondary payor) would pay no more than the program would otherwise have paid in the absence of such private coverage. Furthermore, any medicare payment, when combined with amounts paid by a private plan, could not exceed 100 percent of the amount recognized as reimbursable under the private plan (without regard to any deductibles, coinsurance or copayments imposed by such private plan) or, if higher,

the amount recognized as reasonable under medicare (without regard to any deductibles or coinsurance imposed by the medicare program).

The committee expects physicians and providers and suppliers of health services to end-stage renal patients to recognize that the purpose of this provision is only to change the coordination of benefits relationships between medicare and private health benefit coverage to the extent that any private coverage is present at the onset of end-stage renal disease. Reimbursement for covered expenses for care of such patients is still assured, though the apportionment of such expenses between private plans and medicare will be somewhat different for the initial 12-month coverage of those patients who have other health benefit coverage. Therefore, the committee expects that no end-stage renal patients will be denied needed care or services by reason of the enactment of this coordination of benefits provision. The committee intends that the provision would not result in a reduction in medicare beneficiaries combined protection under the medicare and private insurance programs. The committee is also concerned about potential job discrimination resulting from this action, and directs the Secretary to investigate promptly complaints of this nature, and report his findings to the Congress. The coordination provision would be effective with the date of enactment.

The bill also would deny deduction as a business expense to any employer the expenses paid or incurred by such employer for a health plan, if such plan contains a discriminatory provision that reduces or denies payment of benefits for renal patients. This provision would be effective with taxable years beginning on or after January 1, 1982.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$95
1983.....	165
1984.....	180

MEDICARE PAYMENTS SECONDARY TO FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM PAYMENTS

(Section 720I of the Bill)

Present law.—Under present law, Federal employees and annuitants and their dependents or survivors receive health insurance protection under the Federal Employees Health Benefits (FEHB) program authorized by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901) as amended. The Federal Government contributes, on the average, 60 percent of the premium cost of the health plan chosen by a FEHB program enrollee, with the enrollee paying the balance. The actual percentage of the Federal contribution varies depending on the plan selected, but in no case does the Federal Government pay more than 75 percent of the premium cost.

When an active or retired Federal employee reaches age 65 (or has received social security disability benefits for 2 years), he qualifies for medicare part A (hospital) coverage if he is eligible for

social security benefits. In addition, he may voluntarily purchase medicare part B coverage. The medicare program (except in a few instances) makes payment for covered medical expenses first, without regard to any other health benefits to which an individual may be entitled. As a result, when health expenses are incurred by an individual with entitlement under both the FEHB program and medicare, and the expenses are covered under both programs, medicare makes payment first for the covered services. The FEHB plan in which the individual is enrolled then pays up to 100 percent of the remaining covered expenses—i.e., the FEHB plan pays only to the extent that medicare has not already paid for the services covered by the FEHB plan.

Committee amendment.—Effective January 1, 1982, the bill provides that for Federal employees and annuitants who have coverage under both the medicare and FEHB programs, the medicare program would become the secondary payor, paying only those bills for covered services which have not been paid by a FEHB plan; the FEHB plans would thus become the payors of first resort for medicare eligibles. The medicare payments would be made without reduction for the medicare deductibles or coinsurance. However, the amount that medicare would pay toward the medical expenses of individuals with dual entitlement under both the medicare and the FEHB programs could not exceed the amount which medicare would otherwise have paid if the expenses were not covered by a FEHB plan. In addition, the bill provides that medicare payments for those with dual entitlement, when combined with the amount payable under a FEHB plan, may not exceed an amount equal to (1) the amount that medicare would have paid with respect to the individual in the absence of a primary payor; plus (2) the amount that the FEHB plan would have paid with respect to the individual if it had been the secondary payor. The committee intends that the provision would not result in a reduction in medicare beneficiaries' combined protection under the medicare and FEHB programs.

The committee bill would permit the Secretary of HHS and the Director of OPM to enter into an arrangement for the coordination of payments under medicare and the FEHB plans that would greatly facilitate administration. Under the proposed coordination arrangement, medicare and FEHB plan claims would continue to be processed in exactly the same manner as under present law, thus avoiding any disruption of existing beneficiary and provider billing practices or of the claims processing policies and procedures of the many private health benefit organizations that process medicare and FEHB plan claims. The extent of the medicare overpayments (i.e., the FEHB plan underpayments) that would result would be actuarially determined on an aggregate basis. Provision is made for the medicare program to recoup its excess payments by having the Director of OPM transfer to the appropriate medicare trust funds the amounts needed to put the two programs in the same position as they would have been in had the FEHB plans actually paid first, and had medicare merely filled in the gaps in the FEHB coverage.

Estimated savings.—(net to the budget)

Fiscal year:	Millions
1981.....	
1982.....	\$360
1983.....	590
1984.....	590

C. PROVISIONS RELATED TO MEDICAID

PROGRAM BACKGROUND

Medicaid, authorized under Title XIX of the Social Security Act, is a federally aided, State-administered program of medical assistance for certain categories of low-income persons. An estimated 21.7 million people received program services in fiscal year 1980. Federal program outlays were approximately \$14.0 billion in that year while State funds represented \$11.2 billion.

Under the current law the Federal Government matches whatever States expend under their medicaid programs. Each State designs its own medicaid program within certain Federal guidelines and requirements. Thus there is substantial variation among the States in eligibility requirements, range of services offered, limitations imposed on such services, and reimbursement policies. The Federal Government helps States share in the cost of medicaid services by means of a variable matching formula that is periodically adjusted. The matching rate, which is inversely related to a State's per capita income, ranges from 50 percent to 83 percent. The Federal share of administrative costs is 50 percent except for certain items where the authorized rate is higher.

Eligibility.—States having medicaid programs must cover the “categorically needy.” In general, categorically needy individuals are persons receiving cash assistance payments under the Aid to Families with Dependent Children program (AFDC) or aged, blind, or disabled persons receiving benefits under the Supplemental Security Income program (SSI). A State must cover under medicaid all recipients of AFDC payments. A State is, however, provided certain options (based, in large measure, on its coverage levels in effect prior to implementation of SSI in 1974) in determining the extent of coverage for persons receiving Federal SSI benefits and/or State supplementary SSI payments. States may cover certain additional groups of persons as “categorically needy” under their medicaid programs. These might include persons who would be eligible for cash assistance, except that they are patients in medical facilities (other than for persons under 65 who are in mental or tuberculosis institutions).

States may also include the “medically needy”—those whose incomes and resources are large enough to cover daily living expenses, according to income levels set by the States, within certain limits, but not large enough to pay for medical care, providing that they are aged, blind, disabled, children or parents of families with dependent children. States may also include all needy and medically needy children under the age of 21, even though they are not eligible for assistance under one of the cash assistance programs.

All States (except Arizona) and the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands,

have medicaid programs. Twenty jurisdictions cover only the "categorically needy;" 34 cover both the "categorically needy" and the "medically needy."

Services.—Federal law requires States to include the following basic services in their medicaid programs; inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing facility services for individuals 21 and older; home health care services for individuals eligible for skilled nursing services; physician's services; family planning services; rural health clinic services; early and periodic screening, diagnosis and treatment services for individuals under 21; and effective July 1, 1981 nurse midwife services. In addition, States may provide any number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc. For both the mandatory and optional service, States may set limitations on the amount, duration, and scope of coverage (for example, a limitation on the number of days of hospital care or the number of physician visits).

Under current law, medicaid recipients are permitted to obtain medical assistance from any institution, agency, community, pharmacy, or person qualified to perform the service if such individual or entity undertakes to provide it. This is known as the "freedom of choice" provision.

States, in general, determine the reimbursement rate for services, except for inpatient hospital care, where they are required to use medicare's reasonable cost payment system unless they have approval from the Secretary of Health and Human Services to use an alternative payment methodology. States are required to reimburse skilled nursing facilities and intermediate care facilities at rates that are reasonable and adequate to meet the cost that must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. Generally, for other services, States may establish their own reimbursement levels, provided the amounts do not exceed what would be allowed under medicare. Payments for covered services are made directly to the provider of services and the provider is required to accept the medicaid payment as payment in full for covered services.

Federal law permits States to impose nominal copayments and deductible amounts with respect to optional services for the categorically needy and for all services for the medically needy. In addition, nursing home residents are required to turn over their excess income to help pay for the cost of their care; as a minimum they are allowed to retain \$25 monthly for their personal needs.

CAP ON FEDERAL MEDICAID EXPENDITURES

(Section 721 of the Bill)

Present law.—Under present law, the Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula that is periodically adjusted. The matching rate, which is inversely related to a State's per capita income, may range under current law from 50 percent to 83 percent. The Federal share of

administrative costs is 50 percent except for certain items where the authorized rate is higher.

The Federal Government matches whatever States expend under their Medicaid programs provided certain requirements are met. The Federal government, therefore, has little effective control over the size or rate of increase in the amount of dollars spent under this open-ended entitlement program. Federal costs under Medicaid rose 433 percent from fiscal year 1970 to fiscal year 1980. Federal costs rose 14.9 percent in fiscal year 1979 and 13.8 percent in fiscal year 1980. The Administration has projected increases in Federal outlays under the current program of 18.1 percent in fiscal year 1981 and 10.7 percent in fiscal year 1982.

Committee amendment.—The committee feels that controls must be placed over the amount of Federal spending under the medicare program. The bill, therefore, establishes a limit ("cap") on the amount of Federal financial participation in the program. For fiscal year 1982, Federal expenditures would be allowed to increase 9 percent over the States' estimates for fiscal year 1981. The State estimates on which the calculation is to be based are the latest received by the Secretary prior to April 1, 1981. For fiscal year 1983 and thereafter, Federal spending would be allowed to rise at the rate of inflation for that fiscal year as measured by the Gross National Product Implicit Price Deflator (which measures general inflation in the economy) as set forth in the President's proposed budget for that year.

Several items would be outside the ceiling and therefore be excluded from the base on which the cap is calculated. Funding for Medicaid Management Information Systems and State Medicaid Fraud Control Units, would not be subject to the limitations. It is intended that States will continue to introduce efficiencies in their management information systems and intensify their efforts to curtail fraudulent and abusive activities. The bill also excludes four other items from the ceiling: payments to Indian Health Service facilities, interest payments owed to the State in connection with disputed claims, payments for prior year claims, and payments for the pneumococcal vaccine for the aged.

The bill would also retain the annual ceiling on Federal funding for medicare programs in the territories. The limit for Guam, and the Virgin Islands, would remain unchanged from current law while Puerto Rico's limit would be increased from \$30 million to \$45 million beginning in fiscal year 1982. The Northern Mariana Islands would be subject to the same percentage increase limits as the States. To enable the States to adjust to the reduced funding level, the bill contains several provisions intended to provide States with greater flexibility in designing and quickly amending certain eligibility, benefit, and reimbursement provisions of their medicare plans.

The estimates shown below include savings which result from the operation of the cap on Federal medicare spending, the increased flexibility given to States, and the decrease in the Federal minimum matching rates from 50 percent to 40 percent.

Estimated savings.—

Fiscal year:	Millions
1981.....	.....
1982.....	\$1, 010
1983.....	1, 630
1984.....	2, 230

FEDERAL MEDICAL ASSISTANCE PERCENTAGE

(Section 722 of the Bill)

Present law.—Under present law, the Federal Government pays a percentage of the expenditures that each State incurs in providing care and services under medicaid. This is called the Federal medical assistance percentage, or FMAP. The FMAP for each State is computed according to a formula based on the State's per capita income. The formula is designed to provide a higher percentage of Federal matching to States with lower per capita incomes, and a lower percentage of matching to States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal matching percentage in that State would be 55 percent. States with per capita incomes greater than the average would have percentages of less than 55 percent. Present law provides that no State shall have a Federal medical assistance percentage of less than 50 percent.

Committee amendment.—The bill reduces the minimum Federal medical assistance percentage from 50 percent to 40 percent. The new minimum would apply with respect to assistance payment for expenditures made by States on or after October 1, 1981. The committee estimates that the FMAP for 12 States and the District of Columbia, currently receiving a 50 percent matching rate, will be reduced as the result of this provision. The specific States and their new minimum matching rates for the two year period, October 1, 1981 to September 30, 1983, follow :

Alaska	40.00
California	41.79
Connecticut	40.81
Delaware	48.16
District of Columbia	40.00
Hawaii	48.29
Illinois	42.59
Maryland	47.95
Michigan	47.69
Nevada	40.00
New Jersey	43.74
Washington	46.82
Wyoming	44.71

Estimated savings.—

(Included under medicaid cap.)

ALLOW ACCELERATED COLLECTION OF UNAPPROVED STATE MEDICAID
EXPENDITURES

(Section 723 of the Bill)

Present law.—Under present law whenever the Secretary determines that a State's claim for Federal financial participation should be disallowed, the State is entitled to a reconsideration. The "Omnibus Reconciliation Act of 1980" (P.L. 96-499) provided that, after the final notice of disallowance, the State could chose whether or not to

retain the amount in controversy until the appeals process has been exhausted. If the State chooses to retain the amount in controversy and the final administrative determination upholds the Secretary's disallowance, the State must return the Federal payments to the Secretary with interest (at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period). With respect to notices of disallowance issued during fiscal year 1981, the States are subject to interest penalties for no more than 12 months, regardless of the amount of time required to conclude the administrative appeals process. With respect to notices of disallowance issued after fiscal year 1981, the maximum period for which a State will be subject to interest penalties is 6 months.

Committee amendment.—The bill provides that the Federal Government shall retain the disallowed medicaid matching funds throughout the appeals process in all cases, including amounts in controversy that were denied in the past. If the appeal is successful, the funds (plus interest) will be returned to the States. The rate of interest is the same as the rate of interest which States pay under the "Omnibus Reconciliation Act" provision.

Estimated savings.—

Fiscal Year:	Millions
1981.....	122
1982.....	*
1983.....	*
1984.....	*

*Included under medicaid cap.

COST-EFFECTIVE SERVICE ARRANGEMENTS

(Section 724 of the Bill)

Present law.—Under present law, medicaid recipients are permitted to choose from among any of the providers, practitioners and suppliers of health services that are covered by a State's medicaid program. This provision was originally intended to permit medicaid patients to choose among qualified vendors of services in the same manner as other patients. In reality, in the case of some services—e.g., laboratory services—the patient, in fact, does not exercise any real "choice" in the selection of the provider. This freedom of choice requirement has in some instances, restricted various State and local efforts to secure health services for medicaid recipients in the most economic and efficient manner possible. The committee also notes that the General Accounting Office (GAO) has found that States often pay higher prices for certain services provided medicaid recipients than do other purchasers. Based on these findings, the GAO has recommended that States be permitted to competitively select vendors of care who can provide quality services in an economical and efficient manner.

Committee amendment.—The bill authorizes the States to establish limits and restrictions with respect to choice by recipients of any medical items and services covered under a medicaid plan. The bill further requires that any limitations or restrictions imposed by a State

regarding recipient freedom of choice must (1) be cost effective and (2) assure that recipients have reasonable access to any covered services affected by such limitations or restrictions. A cost effective arrangement is one that provides for reasonable payment of services, based on a comparison of costs, at which such services of proper quality may be obtained by and are actually available to recipients. A State choosing to employ a particular cost-effective arrangement with one or more vendors of services in a specific locale or part of such State would not be required to have such arrangement in effect in all political subdivisions within its borders. This is to assure that a State would not be precluded from entering into economical arrangements with vendors where at all possible, even though the State is unable to enter into comparable arrangements on a statewide basis.

The bill further repeals section 1903(m) to permit a State to make payment on a prepaid capitation or other risk basis to vendors other than health maintenance organizations. The committee believes that States should not be limited in their search for risk-sharing arrangements to so narrowly defined a group of vendors. The bill also permits the Secretary to waive medicaid requirements in order to permit States to share the savings of cost-effective arrangements with participating recipients.

The committee expects that capitation payment arrangements will be entered into only with organizations that have fiscally sound operations, are capable of providing the service or services contracted for, and manage their operations in a manner that ensures the provision of quality health services to medicaid recipients.

The committee intends that limits or restrictions on freedom of choice of recipients be imposed without depriving recipients of access to quality health care. For this reason, the committee expects, and the bill requires that such recipients continue to have reasonable access to services (taking into account geographic location and travel time) for which they are eligible under a State's plan from qualified vendors of health services who meet all applicable standards required under such plan.

The provisions of this section would be effective upon the date of enactment.

Estimated savings.—

(Included under medicaid cap.)

REIMBURSEMENT OF HOSPITALS

(Section 725 of the Bill)

Present law.—States are required to reimburse hospitals on a reasonable cost basis as defined under Medicare unless they have approval to use an alternate method of reimbursement. The Secretary can approve an alternate system only if he determines that: (1) reasonable cost is paid (although the State may develop its own methods and standards for determining what the reasonable cost is), and (2) the reasonable cost does not exceed the amount which would be determined as reasonable under medicare.

Committee amendment.—The bill provides States with additional flexibility in determining the payment rate for inpatient hospital services. The bill deletes the current provision requiring States to reimburse hospitals on a reasonable cost basis. It substitutes a provision requiring States to reimburse hospitals at rates (determined in accordance with methods and standards developed by the States) that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. The section further requires States to provide assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and periodic audits by the State of such reports. These provisions are consistent with the actions taken by the committee and approved by the Congress as part of P.L. 96-499 with respect to payment for skilled nursing facilities and intermediate care facilities.

The committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs and that application of the reasonable cost reimbursement principles of the medicare program for hospital services is not entirely satisfactory. These principles are inherently inflationary and contain no incentives for efficient performance. Under the bill, States would be free to establish rates on a statewide or other geographic basis, a class basis, or an institution-by-institution basis, without reference to medicare principles of reimbursement. The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care.

The committee expects that the Secretary will keep regulatory and other requirements to the minimum necessary to assure proper accountability, and not to overburden the States and facilities with unnecessary and burdensome paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

The bill modifies the current requirement that payments to hospitals under medicaid cannot exceed the reasonable cost of such services as defined under medicare. Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement, the Secretary would only be expected to compare the aggregate amounts paid to hospitals by medicaid in applying this limitation. A similar aggregate test of reasonableness of medicaid reimbursement would be applicable to physicians.

Estimated savings.—(Included in medicaid cap)

SERVICES FOR THE MEDICALLY NEEDY

(Section 726 of the Bill)

Present law.—Current law requires States to offer a specified set of services in their medicaid plans for the categorically needy. In addition, States may provide any number of additional services if they elect to do so. For the medically needy States are required, at a minimum, to offer either all of the mandatory services or alternatively the

care and services listed in 7 out of the 17 paragraphs in the law defining covered services. If the State elects the latter option it must: (1) provide inpatient physician services to individuals receiving covered hospital or skilled nursing facility services; (2) include home health services for any individual entitled to skilled nursing facility care; and (3) include both some institutional and noninstitutional care and services.

State medicaid plans are required to be in effect throughout the State with certain limited exceptions; this is referred to as the statewideness requirement. Services available to medically needy recipients cannot be greater in amount, duration, and scope than those offered to categorically needy recipients. Further, services available to either the categorically needy or medically needy must be equal in amount, duration, and scope for all recipients within the group except for certain limited exceptions (generally based on age). This is referred to as the comparability requirement.

Committee amendment.—The bill deletes most of the current requirements for required services for the medically needy, thereby giving States greater flexibility in designing their medicaid plans for this population group. Under the bill, States would be permitted to choose the services to be offered to the medically needy without being bound by requirements pertaining to a minimum number of services or a mix of institutional and noninstitutional services. States could also offer one set of services for one medically needy group, for example, the aged, without being required to offer comparable services to another group, for example, families with dependent children. Further, they would be permitted to offer medically needy coverage to some but not all of the groups currently eligible.

The bill retains the medicaid statewideness requirement. Further, it also continues the requirement that home health services must be offered for any individual eligible for skilled nursing facility care.

The committee has removed most of the provisions pertaining to required services for the medically needy in order to permit States to focus their resources on those services most urgently needed by specific population groups. The committee expects that States will continue to offer to those medically needy they elect to cover a range of essential medical services with an appropriate balance between institutional and noninstitutional care.

Estimated savings.—

(Included under medicaid cap.)

OPTIONAL COVERAGE FOR STUDENTS RECEIVING AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

(Section 727 of the Bill)

Present law.—Under the Aid to Families with Dependent Children (AFDC) program States are permitted to limit the definition of dependent children to persons under age 18. At State option, a dependent child may be defined to include students age 18 to 20 who are regularly attending primary, secondary, or vocational school;

further, a State may extend the definition to students age 18 to 20 attending college. Present law requires that State medicaid plans include any individual under age 21 who would be eligible for AFDC if he met the AFDC age or school attendance requirements.

Committee amendment.—Section 60a of the bill amends the definition of “dependent child” under AFDC to persons through age 17, or age 18 if they are completing high school in their 18th year. The bill provides that State medicaid plans may limit coverage to any person under age 19 who meets the definition of dependent child under AFDC. At State option, States may extend medicaid to all persons between the ages of 18–20 or any reasonable classification of such persons.

Estimated savings

(Included under medicaid cap.)

TIME LIMITATION FOR WAIVER REQUESTS

(Section 728 of the Bill)

Present law.—Under current medicaid policy, if a State wishes to amend its State plan or apply for a waiver of a State plan requirement, it submits such proposed change or waiver request to the Secretary. Considerable time often elapses between receipt of the State request and the Secretary’s approval or disapproval thereof.

Committee amendment.—The bill requires the Secretary to approve or disapprove a proposed State plan, plan amendment, or waiver request within 90 days after receiving the State request, or, if later, 90 days after receiving information needed to make a final determination. The committee expects that States will be able to more quickly amend the eligibility, benefit, and payment provisions of their medicaid plans thereby giving them greater flexibility to control the costs of their medicaid programs. The section would be effective on enactment.

Estimated savings

(Included under medicaid cap.)

PNEUMOCOCCAL VACCINE BENEFIT

(Section 729 of the Bill)

Present law.—P.L. 96–611 authorized medicare part B coverage beginning July 1, 1981, for pneumococcal vaccine and its administration. The legislation provided that payment for these services would equal 100 percent of the reasonable charge and not be subject to the deductible and coinsurance requirements.

Committee amendments.—Section 18 of the bill, repeals the pneumococcal vaccine provision of P.L. 96–611. The bill modifies the medicaid program to authorize Federal assistance for pneumococcal vaccines for persons least able to purchase such services on their own. The bill provides that vouchers would be made available on a one-time basis in fiscal year 1982 to non-institutionalized recipients of Federal Supplemental Security Income (SSI) payments who are age 65 or older.

The vaccination service would be available from wherever the SSI recipient normally receives services under the medicaid program or, if not eligible for medicaid, through State or local health department clinics. The Federal Government would provide States with 100-percent matching through the medicaid program, up to a maximum of \$10 per vaccination. In addition, 100-percent Federal matching would be available on a ongoing basis, for the reasonable cost (up to \$10 per vaccination) for providing the service to SSI and medicaid recipients, age 65 and older.

The committee intends that funds made available under this provision would be in addition to those to which a State was otherwise entitled under medicaid and would not be counted toward the limitation on Federal expenditures (i.e., the medicaid cap) provided for under Section 21 of the bill.

The committee expects that the majority of other aged individuals not receiving assistance under this provision will be able to budget for the relatively small charge of a pneumococcal vaccination.

Estimated cost.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$8
1983.....	1
1984.....	1

NONMEDICAL SERVICES FOR CERTAIN INDIVIDUALS

(Section 730 of the Bill)

Present law.—Federal matching under medicaid is only available for services which are primarily medical in nature. Certain associated services are not eligible for Federal matching payments. However, these services while not strictly medical in nature may in fact contribute to improved health, and could potentially postpone or prevent institutionalization. To the extent that institutionalization is deferred or avoided, certain cost savings may result.

Committee amendment.—The bill permits the Secretary to waive the current definition of covered medicaid services to include certain nonmedical support services, other than room and board, which are provided pursuant to a plan of care to an individual otherwise at risk of being institutionalized and who would, in the absence of such services be institutionalized. Such services could include case management, supervised living, home services and nonmedical rehabilitation services approved by the Secretary. A waiver cannot be granted unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any of the recipients of such services. The committee expects that States which have been granted a waiver will examine innovative and cost-efficient means of rendering services to this population group.

Estimated Savings

(Assumed in medicaid cap)

D. PROVISIONS RELATED TO MATERNAL AND CHILD HEALTH BLOCK GRANT

(Section 731 of the Bill)

Present law.—Title V of the Social Security Act authorizes formula and discretionary grants to enable each State to extend and improve services for reducing infant mortality and otherwise promote the health of mothers and children, especially in rural and economically depressed areas. States are required to develop a plan for the provision of maternal and child health services (MCH) and for services for crippled children (CC) and designate a single State agency to administer the plan.

The Title V program provides general health services such as primary and preventive health care for mothers and children, and comprehensive services in designated areas through a "program of projects." Under the program of projects States develop a project in each of 5 areas; maternity and infant care, children and youth, family planning, dental health, and intensive infant care. In addition, title V services for crippled children include (1) surgical and corrective services; and (2) facilities for diagnosis, hospitalization, and aftercare for crippled children and children with potentially handicapping conditions.

Under the current program, States receive about 90 percent of title V's appropriation. The formula grants are drawn from two separate accounts, fund "A" and fund "B." For both MCH and CC services, fund "A" monies are allotted by formula for the States and require a dollar-for-dollar match. In each fiscal year, a State is allotted for MCH and CC services a basic grant of \$70,000 and an additional amount to reflect relative need based on population. For MCH Fund "A," an additional amount is distributed in proportion to the number of live births in each State. For CC Fund "A" the additional amount is based on the number of crippled children under 21 years of age in each State.

Fund "B" monies carry no match requirement. In each fiscal year, \$10 million is allocated from fund "B" for MCH and CC services for States and institutions of higher learning to establish projects to serve the mentally retarded. Of the remainder, at least 75 percent is allocated to States on the basis of State per capita income and either the number of live births (MCH) or the number of crippled children under 21 (CC), with rural births and crippled children given twice the weight of urban births and crippled children. These funds are intended to assist States in carrying out their State plans. The remaining 25 percent or less, known generally as "Reserve B" or "RB" funds, is retained at the Federal level for discretionary grants for special projects of regional or national significance.

Ten percent of the title V appropriation is earmarked for research and training. In addition, 5 percent of the MCH appropriation can be transferred from formula funds, at the request of the Secretary of Health and Human Services (HHS), to be applied to research or training. In addition, the law requires that at least 6 percent of the title V appropriation be used for family planning activities.

In fiscal year 1980, \$357.4 million was appropriated for title V grants to States, \$4.8 for research grants, and \$25.2 for training grants.

Committee bill.—The committee bill amends title V of the Social Security Act to establish an MCH block grant which would continue current MCH and CC services and would consolidate the following programs into the block grant; hemophilia, lead-based paint poisoning prevention, genetic diseases, sudden infant death syndrome, and supplemental security income for disabled children's program. Funds authorized for the consolidated program for fiscal year 1982 and each year thereafter would be \$334,500,000. This amount is equal to 75 percent of the funds which were appropriated for the individual programs during fiscal year 1981.

The committee wishes to acknowledge the cooperation and assistance of the Senate Committee on Labor and Human Resources in developing the proposed program consolidation.

The major purpose of establishing this block grant is to consolidate related programs for mothers and children. The committee believes that the consolidation of related categorical programs will lead to the development within States of a more comprehensive, better coordinated approach for providing health care to mothers and children. By eliminating the complex formulas which determine the amount of Federal money which may be spent for narrowly focused activities, block grants free the States to tailor their programs to each State's individual needs.

The committee recognizes that many areas lack systematic approaches for dealing with health care problems of mothers and children and that this situation is caused, in part, by the proliferation of categorical programs, and by the Federal Government's direct award of project grants to local private organizations that bypass State MCH agencies. These problems, coupled with the lack of coordination at the Federal level, make it difficult for States to develop statewide "systems" of care for mothers and children.

The following is a brief description of the programs consolidated into title V by the committee bill:

Hemophilia is a lifelong inherited blood clotting deficiency transmitted by women to their sons. Title XI, part C, of the Public Health Service (PHS) Act currently authorizes grants and contracts for projects to establish comprehensive hemophilia diagnostic and treatment centers which serve large geographic areas that may encompass more than one State. These centers provide (1) services for all hemophiliacs residing in the center's geographical area; (2) counseling to hemophiliacs and their families; (3) individualized written comprehensive care programs for each individual treated by or in association with the center; and (4) training of professional and support personnel in hemophilia research, diagnosis, and treatment. During fiscal year 1980, the Department of HHS funded 24 hemophilia diagnostic and treatment centers in 16 States serving about 6,000 persons at a cost of \$3 million annually. Services within this program are closely integrated with the title V program. The amount appropriated for fiscal year 1981 was \$3 million.

Childhood lead toxicity afflicts about 1 percent of the 17 million children aged 1 to 5 years in the United States. This problem is particularly prevalent in inner city areas where the exposure to lead paint is greater in older homes. Adverse effects of ingesting too much

lead include blindness, seizure disorders, mental retardation, behavioral disorders, and death. Section 316 of Title III of the PHS Act provides funds for identifying children exposed to lead-based paint poisoning, ensuring prompt treatment for afflicted children, public education efforts on the danger and prevalence of lead-based paint poisoning, and identifying and reducing lead-based paint hazards in and around dwelling units. The Center for Disease Control also provides proficiency testing services for laboratories involved in analyzing blood for lead poisoning. During fiscal year 1980, HHS funded 59 project grants to provide lead-based paint poisoning prevention programs in communities at a cost of about \$11.1 million. In 1980, the program reported grantees screening about 490,000 children and identifying about 35,900 with lead toxicity. Many of these identified children receive health care and treatment through the MCH and CC programs. The amount appropriated for fiscal year 1981 was \$10 million.

Genetic diseases include such diseases as Downs syndrome, cystic fibrosis, hemophilia, sickle cell disease, neural tube defects, etc. Title XI, Part A of the PHS Act currently authorizes grants to establish and operate area-wide networks of genetic testing, counseling, and educational programs. Technical assistance is provided to ensure that those programs are coordinated with other existing health care delivery programs, particularly the MCH and CC services programs. The program also provides for the collection of educational and informational materials relating to genetic diseases and their development and dissemination to health care providers and the general public. During fiscal year 1980, HHS provided funds for 34 area-wide genetic service grants and 11 sickle cell clinics to organizations, mostly State health agencies, in 37 States, the District of Columbia, and Puerto Rico at a total cost of approximately \$11.6 million. Grantees served about 2.7 million persons. The amount appropriated for fiscal year 1981 was \$13 million.

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of an apparently healthy infant which cannot be explained by a thorough post-mortem examination or autopsy. Title XI, part B of the PHS Act currently authorizes several SIDS activities including: (1) the creation of a coordinated and comprehensive system of services for survivors of SIDS victims, including case identification, the certification and prompt notification of the family about the cause of death and the provision of counseling support; (2) the collection and analysis of data gathered by the SIDS Information and Counseling project grantees; and (3) the development and dissemination of accurate and current information and educational materials for various professional and paraprofessional personnel as well as for the general public. As of October 1, 1980, 42 SIDS projects covered 34 States and the District of Columbia entirely and parts of 2 other States. The 1980 funding level for the program was \$2.8 million. Approximately 5,500 families received counseling under this program. The amount appropriated for fiscal year 1981 was \$3 million.

Section 1615 of the Social Security Act authorizes formula grants to the States to provide counseling, development of individualized service plans, and referral for service for disabled children under age 16;

and medical, social, developmental, and rehabilitative services for disabled children under age 7 who have never attended public school. During fiscal year 1979, 48 States and the District of Columbia participated in the program. Prior to fiscal year 1980, program funding had been at the rate of \$30 million annually. In fiscal year 1980, States received about \$20 million and provided services to 50,000 children. Funding for fiscal year 1981 was \$30 million.

In consolidating the various programs, the committee intends that States be permitted to use their title V funds for any of the services and activities that were previously authorized under the separate programs being merged. The block grant approach leaves the States free to determine the specific MCH activities to be funded and how to carry out individual State programs.

The committee bill also seeks to assure mothers and children (in particular those living in poverty with limited availability of health services) access to quality MCH services at a reasonable cost. In addition, it adds the reduction of the cost of in-patient care and long-term care services as a stated purpose of title V. Although, the committee believes that the title V program has effected major savings in the cost of in-patient hospital care and long-term care services for persons with handicapping conditions by emphasizing preventive care, this objective was not formally stated and accomplishments in this area have not always been systematically tabulated or reported. By making cost savings a specific program objective, the committee expects the States to be in a better position to demonstrate the value of the MCH program.

The bill also provides funds for carrying out special projects of regional and national significance (including grants for maintaining the hemophilia program) training, and research. The funds available for these purposes would equal 10 percent of title V's total appropriation for 1982 and amounts not to exceed 10 percent of the appropriation for subsequent years. However, the committee believes that the States should themselves encourage and fund multistate regionalized health care efforts where they are cost-effective. In many instances the activities funded under title V and other programs being consolidated in title V are or could be regional in nature, serving persons from multi-state areas. Such activities include regionalized prenatal care centers, genetic disease centers, and hemophilia treatment centers as well as specialized training programs which serve persons from several areas of the Nation. These may include programs to train nurse midwives or MCH providers and planners. Because of their special relationship to the Federal government, Indian maternal and child health projects could be funded as projects of National significance.

To promote accountability and coordination, the committee bill requires that the Secretary of HHS designate an organization within the Department to administer the Federal discretionary grants program, promote coordination at the Federal level among agencies involved in related activities, disseminate information to the States, provide technical assistance and consultation upon request, and assist in the preparation of reports to Congress on program activities and accomplishments.

Under the bill a formula is established allocating funds to the States which would provide 25 percent reduced funding from the fiscal year 1981 level received by the States from the separate programs being consolidated. The committee recognizes that the formula may not be the most equitable way to allocate funds especially with the passage of time. Therefore, the bill requires the Secretary to study and recommend to Congress a more equitable formula for use in the future.

In developing such a formula, the committee expects the Secretary, to the extent practicable, to consider those factors which indicate the relative need for services authorized under this title. Such factors include, but may not be limited to, (1) population (including the number of women of childbearing age), (2) income of State residents, (3) degree of medical underservice in the State, (4) the number of births, (5) the incidence of infant mortality (including SIDS), low birthweight, and handicapping conditions, (6) the number of crippled children and other children in each State in need of services authorized under this title, (7) the number of disabled children in each State under age 7, (8) the number of admissions to neonatal intensive care units or the number of other hospital admissions for the target population, (9) the availability of other resources in the State to meet the needs addressed by this title, and (10) the taxable wealth of the State.

The committee also expects the Secretary to consult with the States and interested organizations in developing this formula.

The committee bill also requires that to receive their full allotments under the bill for fiscal years 1982 and thereafter, States cannot decrease their own expenditures for the activities under the consolidated programs below a specified level. If the full amount of Federal title V funds which is authorized is appropriated for fiscal year 1982 or a subsequent year, this level of State spending for that year for all the consolidated programs would be equal to 75 percent of the State's required expenditures for fiscal year 1981 under fund "A" for MCH and CC services. States that spend less would have their Federal allotment reduced proportionately.

The committee believes that State funding will help ensure that States continue to take interest in using the Federal funds authorized under the bill efficiently and effectively and that Federal funds will complement State funding. The committee believes that the bill's provisions for State funding will necessitate beneficial participation in planning and monitoring use of Federal funds by both State legislatures and Governors.

An evaluation of the effect of this provision as well as the desirability of instituting State matching requirements would be included in the Secretary's report to Congress.

The committee bill provides that States may use their funds for any purposes described in the bill, including planning, administration, education, and evaluation with the following exceptions. Funds could not be used for cash payments to intended recipients of health services; the purchase of improvement of land, or the purchase, construction, or permanent improvement (other than remodeling) of any building or facility; satisfying any requirement for the expenditure of non-

Federal funds as a condition for the receipt of Federal funds; or inpatient services to the extent disapproved by the Secretary.

In giving the Secretary authority to disapprove use of funds for inpatient services the committee intends that he exercise it sparingly and only to ensure that States do not substantially increase their use of funds for in-hospital care as opposed to funds directed towards preventive and primary care for mothers, infants, and children. Also, the committee does not intend to preclude States from using funds authorized under this title for in-hospital services for crippled children in a manner similar to that in which States have previously done under their CC programs.

To provide States with added flexibility, the committee bill provides that a State may transfer up to 10 percent of their title V Federal funding for use under other provisions of Federal law providing for support of block grants administered by the Department of HHS for health services, health promotion and disease prevention or social services, or for meeting home energy and emergency assistance needs. However, the bill restricts such transfers only to those other block grants having reciprocal provisions.

The committee bill establishes a requirement that prior to the expenditure of funds, the State must prepare a report on the intended use of the funds. The report would include a consideration of the needs of the State for title V services, a statement of realistic goals and objectives for meeting those needs, information on priorities and the types of services to be provided and the categories or characteristics of individuals to be served, and a description of the progress made in meeting the States' service and outcome goals. Such goals might include but not be limited to improvements in: availability of prenatal, delivery, and postpartum care to medically underserved women; the percentage of children, with special emphasis on preschool children, appropriately immunized against disease; numbers of children receiving health assessments and follow-up diagnostic and treatment services in accordance with appropriate medical standards; reduction in infant mortality and the incidence of preventable diseases and handicapping conditions among economically disadvantaged populations; and the proportion of eligible children who have a regular source of care for routine preventive and treatment services.

In preparing their reports the committee encourages States to develop one document that will satisfy its own purpose as well as the bill's requirements.

Information provided by these reports will be critical for evaluating the program nationally, documenting program accomplishments, justifying requests for appropriations, and identifying areas where States are experiencing particular difficulty which may require technical assistance from the Secretary, use of secretarial funds available for projects of regional or national significance, or identifying the need for legislative changes, such as alterations in the funding allocation formula.

Audits are required every two years. The committee believes this is necessary in view of the great latitude being given States under this title. Adequate controls and monitoring must exist to (1) prevent and

detect fraud, abuse, and illegal expenditures and acts; (2) identify inefficient practices; and (3) measure program effectiveness.

In addition to independent audits at the State level, the committee expects the Department's Inspector General and GAO, under their basic legislative responsibilities, to audit and evaluate the operations and activities conducted by the Secretary and the State pursuant to this title.

The committee notes GAO's recommendation that consolidation of at least the outreach and screening components of EPSDT and the MCH program would enhance the effectiveness of both. While the committee acknowledges the potential of such a consolidation, it believes the matter warrants further study and evaluation.

Finally, the committee bill requires coordination with other programs. In particular, the State agency administering title V is required to participate in the coordination of activities between title V and the EPSDT program under medicaid. The committee believes that coordination between these two programs will enhance their effectiveness by, at a minimum, avoiding duplication of effort and effecting better and more organized outreach, screening, and follow-up efforts.

The committee bill also requires the State MCH program to coordinate activities with related programs such as the supplemental food program for women, infants, and children (WIC), related education programs, and other health and developmental disability programs, including the family planning program.

GAO stated the need for closer coordination among MCH-related programs in its April 1 testimony before this committee and in its January 1980 report. There has been a proliferation of different programs that have similar objectives, provide similar or related services, or serve the same target population as the MCH program. In many instances, there is little or no coordination among these programs. GAO has pointed out a number of problems resulting from this fragmentation and lack of coordination, including duplication of efforts in some areas while other needy areas go unserved or underserved; pregnant women and infants in some areas receiving supplemental foods but no health services while persons in other areas received health services but no supplemental foods; and lack of cooperative efforts among the public and private sectors and among organizations planning for services for the same population group.

The committee believes that the establishment of block grants, coupled with a substantial budget reduction, provides not only a unique opportunity but also a necessity, for State agencies administering Federal health and health-related programs to work closely together to develop the most efficient and effective ways to maximize the availability and accessibility of services in the most cost-effective manner. Accordingly, the committee expects that the States will make every effort to achieve the maximum degree of coordination among programs.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$46
1983.....	123
1984.....	169

E. PROVISIONS RELATED TO UNEMPLOYMENT COMPENSATION (PART E OF TITLE VII)

ELIMINATION OF NATIONAL TRIGGER FOR EXTENDED COMPENSATION

(Section 741 of the Bill)

Present law.—In most States, unemployment benefits are payable under the regular State program of unemployment compensation for a maximum of 26 weeks. The costs of these regular benefits are financed entirely from State unemployment taxes. In times of high unemployment, however, the Federal-State Extended Unemployment Compensation program becomes operative. This program provides for an additional benefit duration for workers who have exhausted their entitlement to regular State benefits. Benefits are payable under the extended benefits program for half as many weeks as were payable under the regular program. In other words, when the extended benefits program is in effect, unemployed persons can receive up to 13 additional weeks of benefits for an overall maximum of 39. Half of the cost of extended benefits is paid from State unemployment taxes and half of the cost is borne by the Federal Unemployment Tax.

Present law provides for the extended benefits program to be operative in any State when the insured unemployment rate (the number of persons receiving unemployment benefits as a percentage of persons working in jobs covered by the program) is sufficiently high under any one of three tests or "triggers." Under the basic State trigger, the program is in operation when the insured unemployment rate for the State is at least 4 percent and at least 20 percent higher than the average insured unemployment rate in that State during the comparable period in the two prior years. If the State insured unemployment rate is not at least 20 percent above the rate for the 2 prior years, a State may nevertheless elect to have the extended benefits program become effective whenever the State insured unemployment rate reaches a trigger level of 5 percent. In addition to the basic and optional State trigger provisions, present law also includes a national trigger. When the national insured unemployment rate is at a level of 4.5 percent or higher, the extended benefits program must be operated by all States.

Committee amendment.—The committee amendment would eliminate the national trigger for paying extended unemployment benefits. Unemployment benefits are provided to protect workers against the involuntary loss of income that occurs when they lose their jobs and for the period thereafter while they are trying to obtain new employment. In times of high unemployment, the availability of jobs is curtailed and the competition for them is increased. At such times, it is likely that an unemployed worker will need more time to find a new job. This relationship between the overall level of unemployment and the amount of time it takes to find a new job is the basic justification for a program of extended benefit duration. The committee believes, however, that this relationship is more properly reflected in the State triggers than in the national trigger. When a worker becomes unemployed, the question of how long he will have to search

for new employment is dependent upon the availability of, and competition for, jobs in the area where he resides, not upon the national average unemployment situation.

When the extended unemployment compensation program was originally enacted in 1970, extended benefits could be triggered on for an individual State only if the State insured unemployment rate was both 4 percent and at least 20 percent higher than in the 2 preceding years. In the case of a prolonged national recession, States would be unable to meet the "20 percent higher" requirement even though they might be experiencing a very high level of insured unemployment. For this reason, the national trigger did serve as an important safeguard under that original legislation. In the 1976 amendments, however, the law was changed to provide for an optional alternative State trigger based on an absolute State insured unemployment rate of 5 percent. The committee believes that this change in the law eliminated the need for a national trigger.

The elimination of the national trigger would be effective on the date of enactment if an extended benefits period is not in effect on the basis of the national trigger for the week in which such date occurs. If there is an extended benefits period in effect on the basis of the national trigger for the week in which such date occurs, then the effective date would be the earlier of July 1, 1981, or the week following the week in which there is a national "off" indicator ending the extended benefits period.

The elimination of the national trigger was reported by the Finance Committee and passed by the Senate in a number of bills, but never agreed to by the House.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$297
1982.....	657
1983.....	
1984.....	

CHANGE IN EQUATION FOR RATE OF INSURED UNEMPLOYMENT

(Section 742 of the Bill)

Present law.—The Department of Labor presently includes extended benefits claimants in the insured unemployed population used to calculate the trigger unemployment rates for the extended benefits program. This means that two States with essentially identical levels of unemployment will have different insured unemployment rates if the extended benefits program is in effect in one State and not in effect in the other. In 1980 the Secretary of Labor issued a regulation that excluded extended benefits recipients from this calculation, but the U.S. District Court overruled the regulation, stating that: "... an individual who files a claim for benefits under the extended benefits program is no less an individual filing a claim for unemployment than one who files under the "regular" scheme. Reinterpretation of the phrase in the question ("individuals filing claims for unemployment") is therefore a depar-

ture from the plain language of the (Social Security) Act. If the Act is to be amended, Congress, not the Secretary, must do the amending."

Committee amendment.—The committee amendment would exclude extended benefits claimants from the insured unemployed population used to calculate the State trigger insured unemployment rate, effective on the date of enactment. This would lower the insured unemployment rate when the extended benefits program has triggered on in a State. The committee believes that this would correct the current unequal treatment between States with otherwise identical unemployment situations. It would also help to avoid prolonging the availability of extended benefits during the early stages of an economic recovery when more jobs become available and there is less need for the benefits.

The Finance Committee reported this provision in H.R. 4007 in the 96th Congress, but the bill died without further Senate action.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$208
1982.....	561
1983.....	380
1984.....	120

CHANGE IN STATE TRIGGER FOR EXTENDED COMPENSATION

(Section 743 of the Bill)

Present law.—Under present law, when the extended benefits program is not in effect nationally, it may go into effect in individual States on the basis of the State insured unemployment rate. There are two State triggers—a mandatory trigger and an optional trigger. Under the mandatory trigger, States must pay extended benefits when two conditions are met: (1) the State insured unemployment rate is at least 4 percent; and (2) the State insured unemployment rate is at least 20 percent higher than the rate prevailing on average during the comparable period in the 2 previous years. If the 20-percent higher condition is not met, States may, but need not, pay extended benefits if the State insured unemployment rate is at least 5 percent. Fourteen of the 53 State unemployment compensation programs (including the District of Columbia, Puerto Rico, and the Virgin Islands) have not exercised this 5-percent option. (The insured unemployment rate is determined by taking the number of individuals drawing unemployment benefits as a percentage of the number of persons employed in covered jobs. The rate is measured over a moving 13-week period. The cost of the extended benefits program is shared by the Federal Government with the States at a 50 percent rate.)

Committee amendment.—The committee amendment would raise the rates of insured unemployment in the mandatory and optional State extended benefits triggers from 4 and 5 percent to 5 and 6 percent, respectively. The committee believes that this would better target the extended benefits program for States with unusually high unemployment rates. It would be effective the week after September 25, 1982, and consequently, would show no savings in fiscal years 1981 and 1982.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	-----
1983.....	\$92
1984.....	72

QUALIFYING REQUIREMENT FOR EXTENDED COMPENSATION

(Section 744 of the Bill)

Present law.—To be eligible for unemployment compensation benefits, all States require an individual to have worked for a certain length of time or to have earned a specified amount of wages in the base period. These requirements are designed to test the individual's attachment to the labor force prior to loss of employment, and are intended to assure that only workers with reasonably firm attachment to the labor force qualify for benefits.

The most common type of base-period earnings requirement is expressed as a multiple of the weekly benefit amount, that is, the claimant's benefit amount multiplied by a fixed figure. Some of these States also require earnings in at least two quarters to prevent an individual who earns high wages working for only one quarter from qualifying for benefits.

Another requirement used by States is expressed as a multiple of high-quarter wages. The most common multiple is $1\frac{1}{2}$ times, which requires the claimant to have at least $33\frac{1}{3}$ percent of his wages outside the high quarter. Certain States call for a specified number of weeks of employment in the prior year's period. The range is from 14 weeks to 20 weeks. Weeks of employment are defined as weeks in which the claimant's wages exceeded a specified amount, such as \$35. Nearly one-fourth of the States require an individual to have worked a certain number of weeks with at least a specified weekly wage. Still other States require a specified, flat amount of earnings in the base period, such as \$1,000.

There are also some States which have qualifying work requirements which provide for varying periods of eligibility in relation to the amount of each individual's a base period employment.

State qualifying requirements in the 1-year base period break down as follows: (1) Fifteen State programs require a multiple of the claimant's weekly benefit amount ranging from 26 to 40; (2) one State program requires 20 times the claimant's weekly benefit amount outside the high wage quarter in the base period; (3) fifteen State programs require a multiple of the claimant's wages in the quarter with the highest wages, ranging from 1.25 to 1.50; (4) thirteen State programs require weeks of employment that range from 14 to 20; (5) one State program requires a certain number of hours employed; and (6) eight State programs require a flat dollar amount.

Committee amendment.—The committee amendment would require extended benefits claimants to have worked at least 20 weeks or have

its equivalent in wages in the 1-year base period to qualify for benefits, effective for weeks beginning after September 25, 1982. The equivalent in wages may be calculated by the State as either 40 times the claimant's weekly benefit amount or 1.50 times the claimant's wages in the quarter with the highest wages. The State law must specify which calculation will be used.

The committee believes that this amendment will exclude from the extended benefits program claimants with weak pre-unemployment labor force attachment. It will also prevent unemployment compensation benefits from being paid for up to 39 weeks to claimants with less than 20 weeks of employment (or its earnings equivalent) in the 1-year base period.

A nearly identical proposal was reported by the Finance Committee and passed by the Senate in the 96th Congress, but the House did not accept the amendment.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	-----
1983.....	\$11
1984.....	10

ELIGIBILITY REQUIREMENTS FOR EXSERVICEMEMBERS

(Section 745 of the Bill)

Present law.—Presently a servicemember who leaves the military under conditions that were not dishonorable and was not given a bad conduct discharge or, if an officer, did not resign for the good of the service, may receive federally financed unemployment compensation. This means that many servicemembers who voluntarily leave the military may receive unemployment compensation. In contrast, all State programs disqualify, for at least a limited time period, civilians who voluntarily leave their jobs and 40 State programs disqualify them for the duration of unemployment.

Committee amendment.—The committee amendment would disqualify for unemployment compensation benefits exservicemembers who voluntarily leave the military or who were released or discharged for cause—that is, for a reason as determined by the Department of Defense which is comparable to reasons which might cause unemployment benefit disqualification in the case of private sector employment. The committee believes that exservicemembers who voluntarily leave the military should be disqualified much like civilians who voluntarily leave civilian jobs. The amendment is effective on July 1, 1981.

Estimated savings.—

Fiscal year:	Millions
1981.....	\$36
1982.....	265
1983.....	254
1984.....	244

STATE UNEMPLOYMENT LOAN PROVISIONS

(Section 746 of the Bill)

Present law.—Under the Federal-State unemployment compensation system, the basic responsibility for benefit costs lies with the States. All benefits under the regular State unemployment compensation programs are funded through State-imposed payroll taxes. In times of unusually high unemployment, the extended benefits program provides an additional period of benefits (generally for the 27th through the 39th week of compensable unemployment). Half the cost of extended benefits is borne by the proceeds of the Federal unemployment tax and the other half is chargeable to the States.

Ordinarily States are expected to provide adequate revenues to fully meet their obligations to pay all the cost of regular benefits and one-half of the cost of extended benefits. Inasmuch as the demands on the unemployment benefit system vary greatly according to economic conditions, States find it necessary to build up reserves in their unemployment trust fund accounts during periods of relatively high employment so as to be able to meet these benefit payments during periods of recession. Even so, economic conditions are sufficiently unpredictable that States may occasionally suffer temporary shortages in their unemployment fund reserves. To give States the opportunity to correct such shortages in an orderly manner (by increasing revenues or revising the benefit structure), the Federal statute provides authority for temporary borrowing from the Federal unemployment account when this is necessary to enable a State to continue paying benefits.

In the event that a State finds it necessary to make use of the borrowing authority, it is allowed from 23 to 35 months to repay the outstanding loan balance. (The exact period of time depends upon the timing of the borrowing. Repayment is required by November 10 of the second consecutive year at the start of which there was an outstanding loan balance.)

The loan authority is available under present law without any interest and without any penalty for failure to make timely repayment. The only sanction that applies is that repayment of loan principal will be achieved through use of the Federal taxing power if the State fails to meet the statutory deadline. The recoupment of the outstanding loan balance is effected on a gradual basis. The Federal unemployment tax on employers in the defaulting State is increased by a rate of 0.3 percent for the year in which the State failed to meet the repayment deadline. This additional tax is payable as of the following January. So long as a State remains in default thereafter, the Federal tax rate is further increased each year—generally by an additional rate of 0.3 percent each year. This continues until the total Federal tax rate reaches a level of 3.4 percent or until the loan principal has been fully recovered.

Until recently, the loan provisions have generally served their intended purpose as a contingency mechanism to give States a small amount of additional time to deal with occasional fund imbalances. In the past several years, however, this situation has changed dramatically. The recession experienced in the early and mid-1970's found

many States with fund balances well below what was required to meet benefit payments. As a result, heavy borrowing took place to such an extent that the Federal loan account in the unemployment trust fund was itself required to borrow several billion dollars from the general fund of the Treasury in order to satisfy State loan needs. Because of the impact of the recession on the borrowing States, temporary legislation was enacted providing additional time for repayment of the outstanding loans. Altogether, States with outstanding loans were allowed up to 5 additional years (over and above the usual repayment period of approximately 2 years) before any recoupment would be effected.

The temporary legislation permitting additional time for repayment has now expired. A number of States, however, continue to carry large outstanding balances and these balances are projected to grow even larger in the next few years, as illustrated in the table below. This situation is undesirable both from the perspective of the Federal Government and from the perspective of the States involved. Inasmuch as these loans are carried on an interest-free basis, Federal taxpayers in all States are effectively subsidizing the unemployment programs of those States which have outstanding loans. In view of the high levels of interest now prevailing on Federal debt, this subsidy is of significant proportions. Moreover, in a climate of high interest rates, the ability of States to carry these loans on an interest-free basis provides little incentive for the affected States to strengthen the financial situation of their programs.

At the same time, employers in the affected States do face an escalating rate of Federal unemployment taxation designed to recoup the outstanding loans. While this increase in Federal taxes starts at the relatively modest maximum rate of \$18 per year per employee, it rapidly escalates and ultimately can reach as much as \$162 per year per employee. The prospect of continually rising employment taxes to pay off prior year obligations could well interfere with efforts in a State to achieve economic recovery.

Committee amendment.—The committee amendment would revise the unemployment loan provisions to improve incentives for loan repayment while giving States significant relief from the threat of large-scale escalation in the Federal unemployment tax.

Under the committee amendment, any new borrowing by States after the date of the committee decision (May 5, 1981) would be subject to interest at an annual rate of 10 percent. Borrowing already outstanding as of that date would not be subject to interest, but any reduction in a State's total outstanding loan balance would be applied first to reduce the oldest outstanding loans. This would apply both to repayments made from the State unemployment fund and repayments collected by the increase in the Federal tax rate. In this way, States which are able to meet ongoing benefit obligations without any new borrowing would be able to avoid the new interest requirements altogether. However, the amendment provides a strong incentive for repayment of outstanding balances since States would face significant interest on any new borrowing until such time as the total loan balance—old and new—is repaid. Also, by requiring the payment of the oldest loans first, States with new loans after May 5, 1981, would be prohibited

from avoiding some interest charges while continuing to carry the old loans.

The committee recognizes that some States experience temporary cash flow problems because of seasonal employment patterns which result in benefit obligations being highest at the time when unemployment tax receipts are lowest. While States would generally be able to accommodate this situation within the resources of their unemployment account reserves, there may be an occasional year in which some very short-term borrowing would be needed to get through the leaner months. The committee does not intend to create barriers to the use of the loan authority to help States meet this type of occasional near-term cash flow difficulty. For this reason, the amendment provides that no interest would be charged on a State's borrowing for any fiscal year provided that the State entirely repays all such borrowing before the end of that same fiscal year. This would be true even if a State continues to carry a loan balance which was outstanding prior to the start of the year in question. However, if a State does not fully repay its new borrowing before the end of the fiscal year, that borrowing would bear interest from the date of the advance and any partial repayments would, under the general rules of the amendment, be applied against prior year balances. This special exception to the charging of interest applies only where the repayment of any current-year borrowing is made by the State (that is, it would not apply where the "repayment" resulted from the application of the higher Federal tax rate). In addition, States would be able to avoid interest on cash-flow borrowing within a fiscal year only if the Secretary of Labor certifies that the State's fiscal situation is such that it does not appear likely to need any further borrowing during the first 6 months of the following fiscal year.

Under the committee amendment, interest due on borrowing after May 5, 1981 would generally be payable on or before the last day of each calendar quarter for which it is due. (Interest for new borrowing after the start of any given fiscal year would be payable on or before the last day of that fiscal year since it would only be due if the total amount borrowed is not repaid prior to the end of the fiscal year.)

The committee amendment is designed to avoid a situation in which debtor States would use present unemployment program resources to meet the interest requirements. Such a procedure would defeat the purpose of the amendment which is to provide incentives for debtor States to strengthen the financial position of their unemployment funds. In some cases, in fact, such a procedure would actually result in a State increasing its borrowing to replace the resources diverted to interest payments.

Under the committee amendment, States would be specifically prohibited from using unemployment program resources for the purpose of paying the required interest. This means that payments of interest could not be made from the State unemployment account in the trust fund. Moreover, States would not be permitted to take any action which would have the indirect result of partially or completely using unemployment program resources to meet the interest obligation. For example, a State could not finance the interest payments by a special tax on employers and then grant those employers a tax credit which reduced their State unemployment tax liability.

State Unemployment Loan Situation Under Present Law

[Dollars in millions]

	Out- stand- ing debt	Started borrow- ing ¹	1982 increase in Federal employer tax ²		Expected borrow- ing in fiscal year 1982
			Percent	Amount	
Alabama					\$10
Arkansas	\$64	1980			58
Connecticut	365	1972	1.2	\$75	0
Delaware	49	1975	.9	13	11
District of Columbia	58	1975	.9	19	12
Illinois	1,373	1975	.6	149	522
Indiana					202
Kentucky	52	1981			127
Maine	36	1975	.6	13	0
Michigan	1,015	1980			733
Minnesota	114	1980			63
Missouri					160
New Jersey	646	1975	.6	114	87
Ohio	600	1980			709
Pennsylvania	1,585	1975	.9	201	421
Puerto Rico	82	1975	.6	27	0
Rhode Island	120	1975	.9	18	16
Vermont	40	1974	.9	9	0
Virgin Islands	6	1975	.6	2	0
Virginia					2
West Virginia	100	1980			76
Wisconsin					156

¹ Indicates year since which State has continuously had some outstanding debt.² Currently expected increase in employer FUTA tax liability for calendar year 1981; payable as of January 1982.

Source: Based on information supplied by Department of Labor.

The interest requirement on new borrowing would make it possible to grant substantial relief to those States facing large outstanding loan obligations without encouraging excessive reliance on the availability of loans. The committee amendment includes measures to provide such relief.

Under the committee amendment, States which have taken the necessary action to restore the solvency of their programs would no longer face the prospect of very large increases in the Federal unemployment tax on their employers. Once the tax rate has been increased by 0.6 percent (that is, a maximum increase of \$36 in the annual tax per employee), no further increases would take place unless the State failed to meet the solvency requirements or unless the State economy sharply improved. (However, the increased Federal tax rate would not be reduced below the level it had reached in the preceding year.)

In the case of a State which did have a sharply improved economy, the Federal tax rate increase to collect outstanding loan principal would be allowed to rise by an additional 0.3 percent even if the State otherwise qualified for the 0.6 percent limit. This additional increase would be effective if the insured unemployment rate (13-week moving average) in the State had declined by 20 percent or more compared with the rate in the prior 2 years.

To qualify for the 0.6 percent limit on the increased Federal tax rate, a State would have to be able to pay current benefit obligations without resorting to any new borrowing. This would be determined by measuring the outstanding loan balance for the State at the end of the fiscal year and comparing it with the outstanding loan balance as of the end of the preceding fiscal year. If the amount owed had increased, the State would not meet the solvency requirements. If the amount owed had not increased, the State would meet the solvency requirements provided that it had not amended its unemployment program so as to decrease the revenues coming into the program or increase the benefit obligations of the program without providing sufficient additional revenues to meet those increased benefit obligations.

The committee recognizes that a State could have difficulty meeting the requirement of avoiding any new borrowing in a case where it experiences unusually high levels of unemployment. The committee amendment would allow that particular requirement to be waived for not more than 2 consecutive years in the case of a State in which the unemployment rate during at least 26 weeks of the year is high enough that the extended benefit indicator for the State is "on". This waiver, however, would be granted only if the State unemployment tax rate (as a percent of total wages) is at least 50 percent higher than the average rate applicable in all States.

The committee recognizes that the loan provisions of the Federal-State unemployment compensation system have been extensively used by a number of States in recent years and that the committee amendments represent a significant change in the way in which those provisions would operate. The committee believes that the changes it is proposing would correct undesirable incentives of the present system and encourage the strengthening of the financial condition of State unemployment programs in a manner consistent with the fostering of economic growth.

The committee believes that the effects of these new provisions should be carefully monitored and evaluated to assure that they do achieve their objectives. For this reason, the committee recommends that all of the new loan provisions should expire as of October 1, 1984. It is anticipated that this would allow the Congress sufficient time to review the implementation and effects of the provisions and to determine whether they should be extended and what modifications, if any, may be appropriate. Under the committee bill, interest would not accrue on any loan balance for periods after September 30, 1984 and the increased Federal tax rate on employers in delinquent States would be applied for taxable years ending after that date (that is for taxable 1984 and subsequent years) as though these provisions had not been enacted. (It is expected that any outstanding interest for the period May 5, 1981 to September 30, 1984 would have been paid prior

to the termination of these provisions. Any State which had failed to make such interest payments would have put itself out of compliance with the requirements of the Federal-State unemployment program and would remain out of compliance until that interest was paid.)

Estimated savings.—

Fiscal year:	Millions
1981.....	\$9. 6
1982.....	207. 0
1983.....	355. 5
1984.....	404. 8

CERTIFICATION OF STATE UNEMPLOYMENT LAWS

(Section 747 of the Bill)

Present law.—The Federal-State unemployment compensation system is based upon the Federal taxing power. Under the Federal Unemployment Tax Act (FUTA) in chapter 23 of the Internal Revenue Code, an excise tax of 3.4 percent is levied on the first \$6,000 of annual wages paid by employers to each of their employees. Most of this tax, however, is not collected since a tax credit of 2.7 percent is granted to all employers who are subject to a State-operated unemployment compensation program which has been approved by the Secretary of Labor as meeting certain requirements specified in the Internal Revenue Code. Each year, on October 31, the Secretary of Labor certifies to the Secretary of Treasury that States have a program which he has approved and that they have not amended their laws in such a way as to discontinue meeting one or more of the Federal requirements for approval. It is not entirely clear in the present statute that a Secretary of Labor could refuse to certify a State on the basis of its failure to come into compliance with a new requirement of Federal law enacted subsequent to the original approval of the State program. Consequently, it has been the practice of Congress in approving new requirements to include with them a specific amendment providing for the noncertification of States which fail to come into compliance with the new requirements.

Committee amendment.—The committee bill includes a number of changes in the unemployment compensation statutes, some of which will require conforming State amendments. In place of adding several new sentences to the certification section dealing with each of these amendments separately, the committee bill simply modifies the certification provision to make clear that the annual certification by the Secretary of Labor is to be based on the state of compliance or non-compliance of the State program with Federal law as in effect for the year to which each certification applies.

In recommending amendments to the Federal-State unemployment compensation program, the committee approved significant modifications in those elements of the system where there is a clear and legitimate Federal interest, such as the extended benefits program which is half-financed from the FUTA tax, provisions involving Federal employees or special Federally funded benefits, and provisions relating to loans from the Federal Government to States. However, since the un-

employment compensation programs are administered by the States, the savings to be achieved under these changes in the law depend in many instances on State compliance with the new rules.

The committee points out that a number of the proposed changes affect the extended benefits program which is funded half with State funds and half with Federal funds. While States generally may simply conform their statutes concerning this program to the new Federal rules, the changes recommended by the committee with respect to this program are essentially in the nature of matching requirements, and it should be possible to handle questions of compliance on a matching basis. The extended benefit program provides for Federal reimbursement of 50 percent of the cost of extended benefits or of sharable regular compensation. In this legislation, the committee modifies the definition of what constitutes extended benefits and specifically provides that no reimbursement may be provided for otherwise sharable regular compensation which does not meet the requirements for extended benefits. If a State simply failed to enact conforming amendments, its payments under this program would no longer qualify as "extended compensation" for purposes of reimbursement since the statute specifically defines extended compensation to include only payments made in accord with State laws which satisfy the requirements of the Federal-State Extended Unemployment Compensation Act.

The committee amendments also, however, include provisions which are not simply a matter of Federal-State matching. Specifically, the loan reform section requires timely payment of interest on new borrowing and prohibits certain practices which might have the effect of circumventing the interest requirements. These provisions can be effective only if affected States undertake to come into compliance.

The committee is aware that the Labor Department in the past has been reluctant to deny certification on the basis of noncompliance with Federal requirements. Because of the heavy penalty noncertification works on employers in a State, this reluctance is understandable in matters involving inadvertent failure to meet a technical requirement or a good faith disagreement between the Secretary and a State as to the precise meaning of a particular requirement. States should not, however, be misled into thinking that the requirements proposed in this legislation can be safely ignored. The committee expects that the necessary changes in State law will be adopted and implemented as may be required by the enacted legislation.

The committee amendment also delays by 1 year the effective dates required in sections 41-44, for certain States. For sections 41 and 42, the delay applies for any State whose legislature does not meet at least 25 calendar days after the enactment of this Act and before September 25, 1981. For sections 43 and 44, the delay applies for any State whose legislature does not meet at least 25 calendar days after the enactment of this Act and before September 25, 1982. The committee believes that State legislatures meeting the minimum necessary calendar days have enough time to comply with the amendments in this bill and those that do not will have enough time to comply within one additional year. This amendment incurs no savings, but is necessary to obtain State compliance with the amendments in sections 41 through 44 of this bill.

F. PROVISIONS RELATED TO AID TO FAMILIES WITH DEPENDENT CHILDREN (PART F OF TITLE VII)

DISREGARDS FROM EARNED INCOME

(Section 751 of the Bill)

Present law.—In determining AFDC benefits, States are required to disregard from the recipient's total income: (1) the first \$30 earned monthly, plus one-third of additional earnings; and (2) any expenses (including child care) reasonably attributable to the earning of such income. The work expense disregard is available to both recipients and new applicants. The \$30 and one-third applies only to those already on the rolls and is not used to determine eligibility.

There is no limit in Federal law or regulations on the amount which States may disregard as work expenses. In order to limit the amount claimed and also simplify the administration of the work expense provision, a number of States establish standard amounts to be used in the case of AFDC recipients with earnings. At the same time, however, they are required to allow recipients to make additional claims for work expenses if they can show they have such expenses. States are free to define which expenses they consider "reasonably attributable," and State policies vary. Some States provide no disregard for child care expenses, paying for care instead through the Title XX social services program. Some States put limits on the amounts they will allow for child care. Many States also have limits on amounts they will allow for such items as lunches, transportation, or uniforms.

After these deductions, whatever income remains is used to reduce the amount of the AFDC grant. The \$30 and one-third "work incentive" disregard does not apply to individuals who terminate or refuse employment without good cause, or who fail to report their earnings.

Committee amendment.—The committee amendment would place limits on the amounts of earned income which may be disregarded as follows:

- The first \$75 of earned income (instead of itemized work expenses under current law);
- then, up to \$160 monthly for the cost of care for each child or incapacitated adult;
- finally, \$30 plus one-third of the remainder of earned income (not already disregarded).

As under current law, the \$30 and one-third disregard would not apply if employment has been refused or terminated without good cause, and the work expense and child care disregards would also be denied. Further, as described below, the committee amendment would limit the application of the disregard to the first four consecutive months in which a recipient has earnings in excess of the standard work expense and child disregards.

The committee believes that the current earned income disregard provisions have resulted in serious problems. Because Federal law neither defines nor limits what may be considered a work-related expense, there is now great variation among the States and many instances of abuse. In addition, the requirement for itemization of in-

dividual work expenses has resulted in administrative complexity and error. It is the committee's belief that the change in the law with respect to work expenses would have the effect of limiting abuse of the work expense disregard and also result in simpler and more accurate determination of benefits.

The committee recognizes, however, that these changes do not address another serious problem with the disregard provisions—the fact that, because of the permanent application of the \$30 and one-third provision, families may remain on welfare even after they are working full time at wages well above the State welfare standard. For this reason, the committee amendment would also limit the application of the disregard to the first four consecutive months in which a recipient has earnings in excess of the standard work expense and child disregards; thereafter, the amount of payment would be determined without benefit of the \$30 and one-third disregard each month that the family continues to receive AFDC and for 12 consecutive months after AFDC is terminated.

The \$30 and one-third disregard was added to the law in 1967 because it was believed that it would operate as an incentive for mothers to move into employment and to become self-sufficient. Statistics indicate that this has not been the case. For many years the Department of Health and Human Services (DHHS) has been conducting a survey of AFDC recipients which includes the question of employment status of mothers. Results of these surveys show that, despite the work incentive and other amendments added to the law in an effort to increase employment, the percentage of AFDC mothers who work has remained constant.

According to the 1961 survey, 14.3 percent of AFDC mothers were working full or part time. In 1967, before the disregard provision was put into effect, the percentage had grown very slightly to 14.9 percent. In 1979, it dropped to 14.1 percent. DHHS statistics also show that under current law AFDC mothers are not achieving the goal of self-sufficiency. Only about 8 percent of AFDC case closings are due to the earnings of the mother. (In California only about 2 percent of case closings are due to the mother's earnings, and in New York only about 3 percent are due to the mother's earnings.)

The committee believes that the \$30 and one-third disregard of earnings should be applied to the initial months in which a welfare recipient is employed. The committee amendment would allow this disregard to be applied for four consecutive months, after which the recipient would be eligible only for a disregard of \$75 plus up to \$160 per child for child care. After a recipient had benefitted from the disregard for 4 consecutive months, he would become eligible for the \$30 and one-third disregard only if he subsequently became eligible for AFDC after 12 consecutive months of non-receipt of AFDC. Applied in this way, the committee believes that the provision would provide a useful buffer to those trying to readjust to employment, but without resulting in keeping families on welfare for an unlimited period. Combined with the other provisions the committee has approved which are aimed at providing employment for AFDC recipients, these changes are expected to decrease welfare dependency, and emphasize the prin-

ciple that AFDC should not be regarded as a permanent income guarantee.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$374
1983.....	384
1984.....	395

DETERMINATION OF INCOME AND RESOURCES FOR AFDC

(Sections 752A and 752B of the Bill)

Present law.—The AFDC statute requires State agencies, in determining need for assistance, to take into consideration any income or resources of a child or relative claiming assistance. Regulations allow States to exclude certain types of resources, and place a limit not exceeding \$2,000 on the amount of real and personal property, including liquid assets, that a recipient may have. States were formerly allowed to value resources on the basis of fair market value. However, as the result of a circuit court decision in 1976, *NWRO v. Mathews*, regulations were changed to require that all resources be valued on the basis of fair market value less encumbrances, or equity value.

Committee amendment.—The committee amendment would place a maximum limit on allowable resources of \$1,000 in equity value per family, excluding the home and one automobile. The value of the automobile would be limited by regulation. States, if they choose, could place a limit on allowable resources at a dollar amount less than the \$1,000 maximum. The committee believes that the present regulatory limit allows AFDC to be provided in situations in which families have resources upon which they could reasonably be expected to draw. The committee also recognizes that the court decision and resulting regulations requiring equity valuation affected many States, which had previously used fair market value, by allowing the exclusion of resources beyond the amounts the States had intended. The committee agreed to limit the value of resources to assure that aid would be restricted to those most in need.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$16
1983.....	17
1984.....	17

COUNTING VALUE OF FOOD STAMPS AND HOUSING SUBSIDIES

(Section 752C of the Bill)

Present law.—States have authority to define the standard they will use in determining AFDC payments. They may have a standard which provides a single dollar amount to cover all basic needs, or they

may provide amounts for certain specified items. The AFDC statute has no provision relating to the consideration of the availability of food stamps or housing subsidies in determining AFDC benefits.

Committee amendment.—The committee amendment would specifically permit States to take into account the value of any food stamps or housing subsidies provided to a recipient, to the extent that the value of these benefits duplicate the amount for food or housing included in the State standard. The committee believes that this provision would encourage States to consider the availability of other types of benefits which AFDC recipients may receive, and thus would mitigate the effects of pyramiding benefits.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$100
1983.....	103
1984.....	105

INCOME LIMIT FOR AFDC ELIGIBILITY

(Section 753 of the Bill)

Present law.—There is no limit on the amount of gross income a family may have and still be eligible for AFDC. In determining benefit amounts, States are required to disregard the first \$30 plus one-third of the remainder of gross earnings, as well as any work expenses (including child care). Because of the disregard provisions, a family may receive AFDC even when it has relatively high earnings.

Committee amendment.—The committee amendment would limit AFDC eligibility to families with gross incomes at or below 150 percent of the State's standard of need. Although the purpose of the disregard provisions was to encourage families to work, with the expectation that they would move toward financial independence and off the welfare rolls, the result has sometimes been the reverse. Families are remaining dependent on public assistance at relatively high income levels. The committee believes that there should be a cut-off point, and that it is reasonable to establish that point on the basis of the amount each State determines to be its standard of need. The standard of need is used to determine whether a family is eligible for any assistance, and a family which has an income more than 50 percent above that standard should not be considered to be in need. This provision is consistent with the view of the committee that welfare assistance should be limited to those who are most in need.

Estimated savings.—

Fiscal year:	Millions
1981.....	(*)
1982.....	(*)
1983.....	(*)
1984.....	(*)

*Negligible savings, assuming the following sequence: \$30 and $\frac{1}{3}$, 4-month rule, and gross income ceiling of 150 percent.

TREATMENT OF INCOME IN EXCESS OF THE STANDARD OF NEED; LUMP-SUM PAYMENTS

(Section 754 of the Bill)

Present law.—Any payments that meet the definition of income—for example, retroactive social security benefits—are counted as income in the month of receipt and any of the payment that is not spent in that month is usually considered as a resource in the months thereafter.

Committee amendment.—The committee believes that lump-sum payments should be considered available to meet the ongoing needs of an AFDC family. The present treatment of such payments has the perverse effect of encouraging the family to spend such income as quickly as possible in order to retain AFDC eligibility. The committee amendment would require that such income received in a month be considered available as income in the month it is received and also in future months. Thus, if such income exceeded the standard of need in the month of receipt, the family would be ineligible in that month. In addition, any amount of the income that exceeds the initial month's needs standard would be divided by the monthly needs standard, and the family would be ineligible for aid for the number of months resulting from that calculation.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$5
1983.....	5
1984.....	5

TREATMENT OF EARNED INCOME ADVANCE AMOUNT UNDER AFDC

(Section 755 of the Bill)

Present law.—Since 1975, the Federal Government has provided a tax credit for low-income workers with children. Under present law, an eligible individual is allowed a refundable credit equal to 10 percent of the first \$5,000 of earned income, for a maximum credit of \$500. The maximum credit is phased down as adjusted gross income (or, if greater, earned income) rises above \$6,000, being reduced to zero for families with incomes over \$10,000. Any individual who is married and entitled to a dependency exemption for a child, any surviving spouse, and any head-of-household who maintains a household for a child is generally eligible for the credit.

Beginning in 1979, employees may file with their employers for advance payment of the credit. Advance payments are added to the paycheck. If an individual receives advance payments during a calendar year in an amount greater than the actual credit determined on his income tax return, the excess must be repaid with the tax return. (However, the individual's benefit amount must be adjusted to provide payments to the individual of an amount equal to the benefits lost because of excess advance payments.) Conversely, individuals whose ad-

vance payments are less than the actual credit are allowed a refund equal to the excess of the actual credit over the amount of advance payments.

The earned income tax credit (EITC) is counted as earned income for purposes of AFDC, regardless of whether it is received as an advance payment or at the end of the year.

Committee amendment.—The committee amendment would count the amount of EITC payable to a recipient on an advance basis in determining the monthly AFDC payment, to the extent and under the circumstances prescribed by the Secretary. This amount would be counted whether or not it was actually received. The committee believes that counting the EITC on a monthly basis is a more valid reflection of the family's actual current need for assistance, helping to ensure that only those truly in need would receive AFDC.

A similar provision was approved by the House during the 96th Congress (H.R. 4904), and was also included in the 1982 Carter budget.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$51
1983.....	49
1984.....	46

INCOME OF STEPPARENTS LIVING WITH DEPENDENT CHILD

(Section 756 of the Bill)

Present law.—Under present law a stepparent's income may not be considered in calculating the AFDC benefit due a stepchild unless the stepparent is legally responsible for stepchildren under State law. The Department of Health and Human Services recognizes five States as having such laws—Nebraska, New Hampshire, South Dakota, Utah, and Washington. Thus, in all other States, families which include a stepparent may receive AFDC regardless of the amount of the stepparent's income. Income may be counted only to the extent that the State agency can determine that the stepparent is actually making a contribution toward the child's needs.

Committee amendment.—The committee amendment would require States to take into consideration a stepparent's income in determining need. The amount of the income would be limited to that amount which exceeds the sum of (1) the first \$75 of the stepparent's earned income, (2) the State's standard of need for a family of the same composition as the stepparent and the other individuals living in the house and claimed by him as dependents for income tax purposes but not included in the AFDC grant, (3) amounts paid by the stepparent to individuals not living in the household claimed by him as dependents for tax purposes, and (4) payments by the stepparent of alimony or child support with respect to persons not living in the household.

The committee believes that this provision would prevent situations in which children receive AFDC even while they are an integral part of a family which may have substantial income. The provision would not require that a person neglect his natural children. Income which is used to pay support or alimony would be disregarded.

During the 96th Congress the Finance Committee reported, and the Senate passed, a similar amendment requiring the counting of stepparent income (H.R. 3434). The Carter 1982 budget also recommended requiring the counting of stepparent income.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$108
1983.....	111
1984.....	113

PROVISIONS RELATING TO EMPLOYMENT OF WELFARE RECIPIENTS

(Sections 757-759 of the Bill)

Present law.—Current regulations prohibit States from requiring an AFDC recipient to work in exchange for an AFDC grant. In addition, although AFDC recipients are required to take acceptable employment if offered, most employable AFDC recipients are in practice required to do no more than register for work and training with the Work Incentive (WIN) program. (Certain exceptions are made for children, the elderly, the disabled, those who live too far from a WIN site and those who care for a child under the age of 6.) After meeting this registration requirement, they can continue to receive benefits without any further work-related activity unless they are selected by the WIN agency to be among those who actively participate in the program. If an individual who is not exempt refuses to participate in the WIN program or refuses to accept employment, his AFDC payment (but not that of the rest of the family) may be suspended unless he can show that his refusal was based on some good cause. On the other hand, if an individual does accept employment, the amount of his AFDC grant is reduced to take into account his additional income from working.

The statute providing for AFDC establishes as a major objective of that program: "to help . . . parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection." This objective reflects the consensus of American society that dependency on welfare is an undesirable situation both from the point of view of society and from the point of view of the individual recipient. In some cases, certainly, it may be an unavoidable situation; and the existence of the welfare program reflects that reality. But even in such cases, the goal should be to minimize insofar as possible the extent and duration of dependency.

Committee amendments.—The committee recommends three optional approaches for encouraging employment of parents in AFDC families, as described below. The desirability of helping welfare families to achieve independence and the importance of employment to attaining that goal has long been recognized. In 1962, Congress added to the AFDC program authority for States to establish community work and training programs for welfare recipients. By 1967, it was clear that despite those programs, dependency on welfare was increasing not decreasing. In its report on the 1967 amendments, this committee

said: "We are deeply concerned that such a large number of families have not achieved and maintained independence and self-support." This committee recommended, and Congress enacted, a new approach—the Work Incentive (WIN) program under which all employable AFDC recipients are required to register for participation in a program aimed at getting them into employment.

The WIN program, as substantially revised in 1971 and in 1980 by amendments proposed by this Committee, remains the only part of the Federal AFDC statute which is aimed specifically at the goal of achieving independence from welfare through employment. This program has enjoyed some success in helping those it has served to attain employment. However, the available resources for the WIN program have limited the proportion of AFDC recipients it can actively serve. The committee believes that changes in the law are needed to enable the States to supplement the WIN program with programs of their own to assist and encourage recipients to attain independence. In recommending such changes, however, the Committee is not proposing to repeal the WIN program nor recommending any diminution in the resources devoted to it.

Over the past several years, methods for encouraging and assisting welfare recipients to move from dependency to employment have been developed by many State and local governments. These developments have been hampered, however, by a long-standing departmental interpretation of the law which holds that States must make AFDC payments in the form of direct welfare grants and may not provide assistance in the form of compensation for employment. In addition, under court decisions, States are precluded from establishing AFDC work programs on any basis which differs significantly from the operations of the WIN program.

The committee believes that States can and, if given sufficient flexibility, will improve the ability of the AFDC program to achieve its statutory commitment to helping AFDC families to attain self-support and independence. The key to independence is employment. Increasingly for American families, the key to independence is the employment of both parents. According to surveys by the Bureau of Labor Statistics, the percentage of mothers of children under age 18 who were in the labor force has steadily risen from 22 percent in 1950, to 30 percent in 1960, 42 percent in 1970, 47 percent in 1975, and 57 percent in 1980. For mothers with children under age 6, the rate of labor force participation has increased from 14 percent in 1950 to 47 percent in 1980.

The Committee recommends that States be given the option of implementing one or more of the following three new approaches to increasing employability of AFDC families.

Community work experience programs

(Section 757 of the Bill)

Under the new community work experience authority, States would be allowed to operate community work experience programs "to provide experience and training for individuals not otherwise able to

obtain employment, in order to assist them to move into regular employment." The amendment provides that the facilities of the State public employment offices may be used to find employment opportunities for recipients under the program. Programs would be limited to those which serve a useful public purpose in fields such as health, social services, environmental protection, education, urban and rural development, welfare, recreation, public facilities, public safety, and day care. To the extent possible, the prior training, experience and skills of a recipient would be utilized in making work experience assignments.

A community work experience program would have to provide: (1) appropriate health and safety standards; (2) that the program does not result in displacement of persons currently employed, or the filling of established unfilled vacancies; (3) reasonable conditions of work, taking into account the geographic region, residence, and proficiency of the participants; (4) that participants will not be required to travel an unreasonable distance from their home; (5) a limitation on the hours of work required which is consistent with the Federal minimum wage or any applicable State minimum wage in relation to the family AFDC and food stamp benefits; and (6) that provision is made for transportation and other costs (up to an amount determined by the Secretary of HHS who shall take into consideration transportation cost and distance travelled) which are reasonably necessary and directly related to participation in the program. Because participants would not be required to work in excess of the number of hours which, when multiplied by the greater of the Federal or the applicable State minimum wage, equals the sum of the amount of aid payable to the family, individuals participating in these programs would have time to seek regular employment.

Persons required to register under WIN would be required to participate in a community work program unless they are currently employed for no fewer than 80 hours a month with earnings not less than the applicable minimum wage for such employment.

Mothers caring for a child under 6 but not under 3 could, at the discretion of the State agency, be required to participate in a community work experience program if child care is available. (Mothers with a child under 6 are not required to register for WIN.)

Individuals who fail to participate in the program would be subject to the same penalties for reduction or loss of benefits which apply to the WIN program.

For purposes of Federal matching, administrative costs would not include the cost of making or acquiring materials or equipment, or the cost of supervision of work. Other administrative costs, as permitted by the Secretary, would be matchable at the 50 percent rate generally provided for the cost of administering the AFDC program.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	-----
1983.....	\$20
1984.....	41

Providing jobs as alternative to AFDC

(Section 758 of the Bill)

The committee amendment would permit States, at their option, to institute a work supplementation program designed to make employment a more attractive alternative to welfare dependency. The basic concept of this approach is that States would utilize part of the funding now devoted to welfare grants to provide or subsidize employment opportunities which would be available on an entirely voluntary basis for individuals who would otherwise be dependent upon AFDC.

Under the committee amendment, States would have broad flexibility to implement a work supplementation program in the manner which they believe will most effectively accomplish the goal of making employment more attractive than welfare. To generate the funding necessary for subsidizing jobs, States could lower all AFDC grant levels or they could lower them selectively for certain geographic areas or for certain categories of recipients whom they determine to be most employable. The funding saved by lowering the grant levels would be used to make jobs available for the recipients affected. In their operation of a work supplementation program, States would be free to fashion programs without having to meet the restrictions which are applicable to work programs under the present law provisions of the AFDC and WIN statutes.

Expenditures by the State to provide jobs directly to AFDC eligibles or to subsidize jobs provided by other employers would qualify for Federal matching on the same basis as expenditures for AFDC grant payments. To qualify for matching, the individual at the time of employment would have to be an AFDC recipient or an individual who would have been eligible for AFDC under the May 1981 State AFDC rules, or as these rules may be modified thereafter by Federal law. Matching would be available for jobs provided directly by the welfare agency or provided by any other public or nonprofit agency with the costs of employment being subsidized by the welfare agency (or by the agency which administers or is authorized to administer the community work experience program). Jobs made available by private for-profit employers would not be eligible for a subsidy with Federal funds except that subsidies could be provided for employment by private child care providers if they do not also claim the WIN or targeted jobs credit for the same employment.

Jobs provided under a work supplementation program would have to be made available on an entirely voluntary basis. Each individual would therefore have the opportunity to determine for himself whether or not the jobs made available under this program were appropriate for him. (If an individual elected not to take a job under the work supplementation program, he would be eligible for AFDC subject to the work requirements which regularly apply to receipt of AFDC under State or Federal law.)

Payments made to an individual under the work supplementation program would be in the nature of compensation for services and would be treated as earned income for purposes of other laws. The committee recognizes, however, that some States might be reluctant to operate a work supplementation program if participants must be considered

to be employees of the agency administering the program and must be given the full range of benefits which accrue to agency employees. Similarly, there is reason to question the willingness of other employers to grant full employee status immediately to individuals whose wages are being supplemented under this program. For this reason, the committee amendment provides that the agency administering the program need not give the participants the technical status of employees of that agency whether it is subsidizing their work for other entities or is directly making payments to them. (The agency could, at its own option, elect to grant such employee status to individuals to whom it is making direct payments.) In the case of individuals placed with other employers, the committee amendment would allow the administering agency to prescribe a period of up to 13 weeks during which participants would be considered to be in subsidized training but would not have the technical status of employees of that other entity.

The committee amendment would provide a significantly different approach to work incentives as compared with the existing AFDC system. To give States the maximum capability to implement a work supplementation program in the most effective manner, the amendment would allow participating States to modify the operations of the AFDC program in ways which conform to the objectives of the work supplementation program. States would be specifically authorized to lower AFDC standards so as to increase the attractiveness of employment as compared with welfare dependency, and could make any necessary further adjustments to correct for offsetting increases which might occur in other needs-based programs, such as the food stamp program. States would also be allowed to vary needs standards either regionally or by recipient category in whatever ways the State finds appropriate in the light of its implementation of a work supplementation program. Inasmuch as the program is designed to provide work incentives in the form of work as an *alternative* to welfare, States would also be permitted to reduce or eliminate the amount of earnings disregarded in calculating an AFDC grant. To avoid the disincentive to employment which might result from the loss of medicaid eligibility, States would be authorized, at their option, to continue that eligibility for individuals who accept employment in jobs subsidized by the work supplementation program.

The committee expects that States operating such a program would be able to achieve an overall reduction in the costs of the welfare program to both the State and the Federal Government. To assure that this can be accomplished, the committee amendment is intentionally designed to give the States broad flexibility which will enable them to phase into the work supplementation program gradually, implementing it first in those ways which appear most likely to reduce overall program costs. As an overriding safeguard against increased costs, the committee amendment would provide that participating States may not receive total Federal funding for their AFDC program (including work supplementation) which exceeds the Federal funding which would apply if they continued to operate their AFDC program under the State plan as it was in effect in May 1981. (This ceiling on Federal funding will be adjusted to take into account changes in the State plan after May 1981 which were made as a result of mandatory requirements of Federal law.)

Work incentive demonstration project

(Section 759 of the Bill)

The committee amendment would authorize States, as an alternative to the work incentive program, to operate a work incentive demonstration program for the purpose of demonstrating single agency administration of the work-related objectives of the AFDC program. Not later than 60 days after the date of enactment, the governor of a State wishing to conduct this kind of demonstration would have to submit to the Secretary of Health and Human Services (HHS) a letter of application providing evidence of intent. There would have to be an accompanying State program plan which specifies: (1) that the operating agency will be the State welfare agency, and (2) that required participation criteria will be the same (statewide) as are applied under the WIN program. However, the components of the program could be varied in different regions or political subdivisions of the State. Earnings derived from participating in the project would not make a family ineligible for AFDC.

These demonstration projects would substitute for the regular WIN program, and each participating State would be funded at a level equal to its 1981 WIN allocation augmented by any other Federal funding which may be available for establishing AFDC work programs in the State. (These funds could be used only for operating the work incentive demonstration project and could not be used for direct grants to participating families.)

The purpose of the demonstration authority is to test the States' ability to develop alternatives to the current AFDC work requirements. The demonstrations would last for 3 years. The Secretary of HHS would be required to conduct two evaluations of a State's work incentive demonstration program. The first evaluation would be conducted after the first 12 months of operation, and the second at the conclusion of the program. The committee believes that the results of these evaluations would provide insight into ways to improve the administrative mechanism of programs which are designed to provide employment for welfare recipients.

EFFECT OF PARTICIPATION IN A STRIKE ON ELIGIBILITY FOR AFDC

(Section 760 of the Bill)

Present law.—The AFDC statute has no specific provision which addresses the issue of eligibility of strikers for assistance. Regulations give States the option of excluding from eligibility a family in which the father is unemployed as the result of participation in a labor dispute. However, 17 States currently do provide assistance to families in which the father is on strike. In addition, all States must pay AFDC to families in which the parent is not required to work, but could be working if not on strike, so long as other eligibility criteria are met.

Committee amendment.—The committee amendment would provide that AFDC would not be payable to a family if a caretaker relative (mother or father) is, on the last day of the month, participating in a strike. If an individual in the family other than a caretaker relative is on strike, that individual's needs would not be included in determin-

ing the amount of the AFDC grant. Further, the amendment specifies that participation in a strike would not constitute good cause to leave or to refuse to seek or accept employment. Striking workers would have to comply with AFDC work registration requirements. The committee believes that the primary purpose of AFDC is to help children of those who are unable to work, not those who choose not to work. Allowing strikers to join the rolls through voluntary action is inconsistent with AFDC policy which requires recipients who are able to work to seek, accept, and retain employment.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$5
1983.....	5
1984.....	5

AGE LIMIT OF DEPENDENT CHILD

(Section 760A of the Bill)

Present law.—The statute allows States to choose from three options for establishing a maximum age for AFDC child eligibility. States may choose to limit eligibility to a child who is: (1) under age 18, (2) under age 21 and a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment, or (3) under age 21 and a student regularly attending a school in grade 12 or below or regularly attending a course of vocational or technical training, other than a course provided by or through a college or university, designed to fit him for gainful employment. Option (3), which allows a State to limit assistance to children in elementary or high school or in vocational training (thus prohibiting assistance for college students) was added by P.L. 96-611.

Committee amendment.—The committee amendment would limit eligibility to a child who is under age 18, or, at State option, under 19, but only if the child is a full-time student in a secondary or technical school and may reasonably be expected to complete the program before he reaches age 19. The committee believes that it is inappropriate for a program which is designed to help children to provide aid for individuals who are ordinarily considered adults. Age 18 is considered the age of majority for purposes of nearly all Federal and State laws. The committee amendment would have the effect of limiting assistance to those under age 18 in most circumstances. The only exception would be if a State decided that it wanted to provide assistance to those who had reached 18, but were still enrolled full time in a program of basic education. AFDC would not be payable on behalf of college students.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$100
1983.....	104
1984.....	108

LIMITATION ON AFDC TO PREGNANT WOMEN

(Section 760B of the Bill)

Present law.—By statute, AFDC is paid on behalf of a “dependent child” who is living with a specified relative. In the case of *Burns v. Alcala* the Supreme Court in 1975 held that the term “dependent child” does not include unborn children, and hence a State receiving Federal matching for AFDC is not required to offer welfare benefits to pregnant women for their unborn children. This left in effect a long-standing regulation that a State may provide payments with respect to an unborn child when the fact of pregnancy has been determined by medical diagnosis. In the *Burns* case the Solicitor General argued on behalf of the Department that unborn children are not included in the Federal eligibility standard and that the regulation authorizing Federal participation in AFDC payments to pregnant women is based on the agency’s general authority to make rules for efficient administration of the Act. A total of 34 States now make some kind of payments on behalf of an unborn child to pregnant women with no other children. The kinds of payments vary, as do provisions specifying at what stage of pregnancy payments may begin.

Committee amendment.—The committee amendment would allow States, at their option, to provide payments to a pregnant woman if it has been medically verified that the child is expected to be born in the month the payments are made or within the 3-month period following the month of payment.

The amendment specifies that the term “aid to families with dependent children” does not mean any amount paid to meet the needs of an unborn child, and does not mean any amount paid (or by which a payment is increased) to meet the needs of a woman occasioned by her pregnancy, unless, as has been medically verified, the child is expected to be born in the month the payments are made (or increased) or within the following three months. The committee recognizes that additional amounts may be required to meet the needs of a woman who is pregnant which would not otherwise be required. Under the committee’s amendment, States would be allowed to meet such needs in the last trimester of pregnancy by providing in their plans for payment for special needs such as a special diet, or a crib, infant’s clothing, or other items needed by the woman to prepare for the birth of the child.

The committee believes that allowing payments only for the last 3 months of pregnancy recognizes the fact that if pregnant women are in need of assistance it is ordinarily only for a limited period prior to delivery.

The committee recognizes, however, that there may be cases in which pregnant women need access to prenatal care, even though they have no need of cash benefits. The committee amendment would allow any State to provide this access through its medicaid program.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$16
1983.....	17
1984.....	17

AFDC BY REASON OF UNEMPLOYMENT OF A PARENT

(Section 760C of the Bill)

Present law.—In 1961 Congress enacted temporary legislation allowing States at their option to provide assistance to families in which a parent was unemployed. In 1967 this legislation was made permanent, but eligibility was limited to families in which only the father was unemployed. In 1979 the Supreme Court held in *Califano v. Westcott* that the restriction to fathers was discriminatory. Since that time, the Department has been operating under an “unemployed parent” concept, and either parent may qualify as the unemployed parent, regardless of whether the other parent is employed.

Committee amendment.—The committee amendment would amend the current statute to allow eligibility on the basis of an unemployed parent (rather than father), but would define an unemployed parent as the parent who earned the greater amount of income in the 24-month period immediately preceding application. The committee believes that eligibility for assistance on the basis of unemployment should be limited to families in which the *principal* wage earner is unemployed. The amendment would prohibit eligibility in cases where the secondary wage earner is unemployed, and thus benefits would better reflect the family’s actual need for assistance.

Estimated savings.—

Fiscal year:	Millions
1981.....	(*)
1982.....	(*)
1983.....	(*)
1984.....	(*)

* Negligible savings.

WORK REQUIREMENTS FOR AFDC RECIPIENTS

(Section 760D of the Bill)

Present law.—AFDC work requirements do not apply to children age 16 and over who are in school (including college), or to adults who are caring for a child under age 6.

Committee amendment.—The committee amendment would limit the work exemption to parents who are providing care for a young child with only brief or infrequent absences from the child. Thus, if the parent is not actually providing full-time care for the child, the parent would not be exempt from the work requirements. In addition, the committee amendment would exempt from the work requirement only those children above age 15 who are attending, full time, an elementary, secondary, or vocational school. The committee believes that the work requirements should be applied in such a way that persons who are able to work are in fact required to do so. AFDC is basically intended to assist persons who cannot work. Persons who choose to attend college do not meet that basic criterion. It is difficult to justify asking taxpayers who may be unable to afford college for themselves or their children to support a public assistance program that enables others to do so.

Estimated savings.—

Fiscal year:	Millions
1981.....	(*)
1982.....	(*)
1983.....	(*)
1984.....	(*)

* Negligible savings.

RETROSPECTIVE BUDGETING AND MONTHLY REPORTING

(Section 760E of the Bill)

Present law.—Under present law, accounting methods for AFDC (that is, the methods States use to compute income in order to determine eligibility and payment amounts) are left to the choice of the States. Some States use a form of retrospective accounting in which benefit determination is based on the recipient's actual circumstances in the prior month. Most States, however, use a prospective method in which benefit determinations for a current month are based on current information and a forecast of circumstances for the remainder of the month.

Regulations issued by the Department of Health and Human Services, effective May 4, 1979, require States to specify in their State plans whether they use a retrospective or prospective budgeting method for AFDC. The regulations specify certain rules which have to be followed under whichever system the State chooses.

If a State uses retrospective accounting, it must require monthly income reports from recipients with earned income, and may require reports from other recipients. As of March 1981, 12 States had adopted the retrospective accounting method: Arizona, California, Idaho, Illinois, Kansas, Michigan, Montana, North Dakota, Oregon, South Dakota, Washington, and Wyoming. (This method is also used in parts of Colorado.) All of these States require monthly reports from recipients with earned income and with work histories. California requires reports from all recipients. In addition, Minnesota, Missouri, and Utah require monthly reports from those with earnings and with work histories, even though they use a prospective accounting method.

Committee amendment.—The committee amendment would require all States to adopt a retrospective accounting and monthly reporting system. Under the retrospective accounting system, States would have to determine a family's eligibility for benefits on the basis of income and other factors in the current month, but the amount of the benefits would be determined on the basis of the circumstances in the previous month, i.e., on a monthly retrospective basis. (At the option of the State, but only where the Secretary determines it to be appropriate, payment amount could be determined on the basis of income and circumstances in the second preceding month. This may be necessary, for example, when the payment date is in the first week of the month and the State needs time to process the required monthly report.) For the first month of the family's eligibility, however, both

eligibility and benefit amount would be determined on a current (i.e., prospective) basis. (At the option of the State but only where the Secretary determines it to be appropriate, prospective accounting could also be used in the second month of the family's period of eligibility.)

The State would require all recipients to provide monthly reports on income, family composition, resources, etc., as a condition of the continued receipt of aid under the plan. These reports would pertain to the just-passed month, as well as to income and other matters relevant to eligibility and benefits expected in the coming month. The State would also be directed to take prompt action, accompanied by concurrent notice to the recipient, to implement changes he reports to the State or to terminate aid for failure to report.

The committee decision is based on the fact that the prospective system used by most States results in unavoidable error in that it is not possible to predict changes which may take place in an upcoming month and which may affect the AFDC payment. Overpayments and underpayments inevitably occur. In addition, at the present time in most States a recipient is required to report changes in income only when they occur. Most States have no formal system for reporting such changes, and delayed reporting is the cause of a significant percentage of AFDC errors. The Department has been conducting experiments using retrospective accounting and monthly reporting. The results show that substantial savings can be made as a result of adopting these procedures through elimination of errors and more rapid adjustment of payments. The experiments have also indicated that recipients are able to meet the reporting requirements and that they do not result in an undue burden.

The committee believes that this amendment would provide a rational, business-like method for securing and processing accurate, up-to-date information on each recipient family. A similar proposal was agreed to by the House in the 96th Congress and was also included in the 1982 Carter budget.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	-----
1983.....	\$187
1984.....	195

PROHIBITION AGAINST PAYMENT OF AID IN AMOUNTS BELOW TEN DOLLARS

(Section 760F of the Bill)

Present law.—State welfare agencies must pay the full amount an AFDC family is entitled to receive under the State's method of determining benefits, regardless of how small that amount may be.

Committee amendment.—The committee amendment would preclude the State from making a monthly payment of AFDC in an amount less than \$10. However, for purposes other than AFDC, any individual

denied aid solely because of this minimum payment provision would nonetheless be treated as a recipient. This provision would eliminate the need to distribute checks for small amounts that may cost more to write and process than they are worth. The amendment would, however, protect families from the loss of other benefits because of this change. This provision was passed by the House during the 96th Congress as part of H.R. 4904. It was also included in the 1982 Carter budget.

Estimated savings.—

Fiscal year:	Millions
1981.....	(*)
1982.....	(*)
1983.....	(*)
1984.....	(*)

• Negligible savings.

REMOVAL OF LIMIT ON RESTRICTED PAYMENTS IN A STATE'S AFDC PROGRAM

(Section 760G of the Bill)

Present law.—Under existing law States are allowed to make protective or vendor payments (including payments in the form of two-party checks), instead of direct cash payments, with respect to recipients of AFDC. The number of recipients with respect to whom such payments may be made in any State may not exceed 20 percent of the State's AFDC caseload. In addition, the law provides that these protective and vendor payments may be made only if there is a determination by the State agency that the relative of the child for whom the payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child.

Committee amendment.—The committee amendment would delete the limit on the percentage of a State's cases to which vendor or protective payments may be made. The 20 percent limit would no longer apply. In addition, the amendment provides that if the individual requests a two-party check or other form of vendor or protective payment, there would not have to be a finding by the State agency that the recipient is unable to manage funds.

The committee believes that removal of the limit will make vendors more willing to provide housing, utilities, and other goods and services to welfare recipients because they will be assured of payment. The committee further believes that recipients should have the option of receiving vendor payments at their request without a finding by the State agency that they are unable to manage their funds.

Estimated savings.—

Fiscal year:	Millions
1981.....	(*)
1982.....	(*)
1983.....	(*)
1984.....	(*)

• No budgetary impact.

ADJUSTMENT FOR INCORRECT PAYMENTS

(Section 760H of the Bill)

Present law.—There are no provisions in the statute specifying how States are to treat overpayments and underpayments. In practice, States are given the option of recouping overpayments, but are not required to do so. Regulations prohibit recoupment of overpayments unless the recipient has income or resources, exclusive of the assistance payment, in the amount by which the agency proposes to reduce payments. In other words, if the individual has no income or countable resources in excess of the AFDC payment, there can be no recovery of overpayments. There is one exception to this provision. Recoupment may be made when overpayments are caused by the recipient's willful withholding of information concerning his income, resources, or other relevant circumstances. In such cases, the agency may recover. If recoupment is from current assistance payments, however, regulations require that the State not cause undue hardship to recipients.

Committee amendment.—The committee amendment would require States to take prompt action to correct both overpayments and underpayments. In the case of an overpayment to a current recipient, the individual would be permitted to repay the amount of the overpayment, or the State would have to offset the overpayment against the AFDC payment for which the individual continued to be eligible. However, the AFDC payment for any month in which overpayments are being recovered, together with the recipient's liquid resources and all income, would have to equal at least 90 percent of the payment that a family would receive if it had no other income. Overpayments to former recipients would be recoverable by whatever civil remedies are available in the State.

The committee amendment would also require that underpayments be promptly corrected by the State agency, and not considered as income, and not considered as resources in the month of receipt or the next month.

The committee believes that a policy of insuring the correctness of payment is crucial if the AFDC program is to continue to have public support. By requiring the correction of both overpayments and underpayments, the committee believes that recipients and welfare agencies alike will be encouraged to take greater responsibility for assuring the accuracy of administration. Although States have been working to improve their administrative procedures and to reduce errors, the committee notes that in the quality control measuring period April–September 1979, 23.5 percent of AFDC cases involved error. The total number of cases involving incorrect payments was 779,100. Nationally, statistics show that 9.5 percent of funds were overpayments, and 0.9 percent were underpayments. In the 6-month period cited above, a total of \$493,979,000 in Federal and State funds were paid to families that were ineligible for assistance or that received payments in excess of the amount payable to them.

Estimated savings.—

Fiscal year:	Millions
1981.....	
1982.....	\$115
1983.....	110
1984.....	106

**REDUCED FEDERAL MATCHING OF STATE AND LOCAL AFDC
TRAINING COSTS**

(Section 760I of the Bill)

Present law.—Under present law, States may receive 75 percent Federal matching funds for costs of training State and local AFDC personnel.

Committee amendment.—The committee amendment would reduce the Federal matching rate to 50 percent, which is the rate generally applicable to administrative costs. The committee believes that raising the State contribution to 50 percent will insure that States scrutinize more closely their training procedures and expenses.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$16
1983.....	17
1984.....	18

EFFECTIVE DATE

(Section 760J of the Bill)

Amendments and repeals made by the committee are effective October 1, 1981, unless a State agency administering the AFDC plan demonstrates to the satisfaction of the Secretary of Health and Human Services that it cannot, by reason of State law, comply with the requirements of the committee provisions. The Secretary may prescribe that in such instances an amendment would become effective the first month which begins after the close of the first session of that State's legislature ending on or after October 1, 1981. The committee expects that the Secretary will work with States to assist them in meeting these provisions.

G. CHILD SUPPORT ENFORCEMENT PROVISION (PART G OF TITLE VII)

**COLLECTION OF PAST DUE CHILD AND SPOUSAL SUPPORT FROM FEDERAL TAX
REFUNDS**

(Section 761 of the Bill)

Present law.—Under current child support statute, the Secretary of Health and Human Services is required, upon the request of a State having an approved child support program, to certify to the Secretary of Treasury for collection by the Internal Revenue Service (IRS) of amounts which represent delinquent child support payments. The Secretary may certify only the amount delinquent under a court order for support, and only upon a showing by the State that it has made diligent and reasonable efforts to collect amounts due, using its own collection

mechanisms, and upon an agreement that the State will reimburse the Federal Government for any costs involved in making the collection. Collections may be made on behalf of both AFDC and non-AFDC families.

Committee amendment.—In recent years individual States have been developing a policy of using their State tax systems for collecting delinquent child support payments. A number of States have had considerable success in collecting child support by withholding State tax refunds due to absent parents. The committee believes that this procedure should also be used at the Federal level, and that it would result in making more effective the IRS collection procedures that are authorized under present law. The committee amendment would amplify existing authority in the following way. Upon receiving notice from a State child support agency that an individual owes past-due support which has been assigned to the State as a condition of AFDC eligibility, the Secretary of Treasury would be required to withhold from any tax refunds due that individual, an amount equal to any past due support. The withheld amount would be sent to the State agency, together with notice of the taxpayer's current address. The Secretary of Treasury would be required to issue regulations, approved by the Secretary of HHS, prescribing the timing and contents of notices by the States. States would be required to reimburse the Federal Government for the cost of the procedure. "Past-due support" is defined as the amount of a delinquency, determined under court order or an order of an administrative process established under State law for support and maintenance of a child, or of a child and the parent with whom the child is living.

The administration has informed the committee that it intends to operate this new procedure as follows:

States will submit annually to HHS reports of delinquent child support cases. They will be submitted on magnetic tape and contain the name and social security number of the absent parent and the amount of the delinquency. HHS will consolidate the cases from all the States and, in turn, submit them to IRS in a format suitable for the technical requirements of IRS.

Tentatively, it is planned that States must submit their requests to HHS in October so that HHS may forward the consolidated request to the IRS in December. IRS will then use this information to offset refunds from tax returns filed between January 1 and April 15. This procedure will be initiated in time to offset refunds owed for calendar year 1981. Amounts offset by IRS will be paid to State child support enforcement agencies.

In summary, there will be two IRS collection procedures available to States. Under the existing procedure, States may submit individual delinquent cases at any time during the year for collection by IRS using its full collection powers. The fee is currently \$122.50 per case. Under the new procedure, States will submit once a year a number of cases on magnetic tape. For these cases, IRS will only offset delinquencies against any tax refund it may owe the absent parent. Because this new offset procedure will be highly automated, the fee for each of these cases will be substantially lower than \$122.50.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$27
1983.....	30
1984.....	33

COLLECTION OF SUPPORT FOR CERTAIN ADULTS

(Section 762 of the Bill)

Present law.—Under current law, a State child support agency is not authorized to collect support on behalf of a parent of a child for whom it is collecting child support. This is the case even when a court has ordered a single amount for both the parent and the child, without specifying the amount payable on behalf of each.

Committee amendment.—The amendment would make State child support agencies responsible for collecting support for a child's parent (with whom the child is living) as well as for the child himself. This will eliminate the current confusion as to what amounts are collectible by child support agencies, and will help to provide a more adequate level of support for children of absent parents.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$23
1983.....	23
1984.....	23

COST OF COLLECTION AND OTHER SERVICES FOR NON-AFDC FAMILIES

(Section 763 of the Bill)

Present law.—States are allowed, but not required, to impose an application fee for furnishing child support collection and paternity determination services to non-AFDC families who request them. HHS regulations provide that a State may charge a flat dollar amount not to exceed \$20, or it may use a fee schedule based on the applicant's income, and designed so as not to discourage the application for such services by those most in need of them. States may also provide for recovering the cost incurred in excess of the fee by deducting such costs from the amount of any recovery made.

Committee amendment.—The committee amendment would require States to retain a fee equal to 10 percent of the support collected. (The optional fee provisions in present law would still be applicable to paternity determination services.) This 10 percent fee would be charged against the absent parent and added to the amount of the collection. Any amounts collected would be used to reduce the administrative costs for which the State claims Federal matching. The committee believes that this mandatory fee provision is necessary to cover the costs to the Federal and State Governments of providing this

collection service. The committee further believes that this provision would encourage States to expand their collection efforts on behalf of non-AFDC families. Some States have been slow to implement child support collection services for non-AFDC families because of the potential costs to them. The 10 percent fee requirement would provide the States with a method of recovering costs which would not be administratively burdensome.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$45
1983.....	49
1984.....	55

CHILD SUPPORT OBLIGATIONS NOT DISCHARGED BY BANKRUPTCY

(Section 764 of the Bill)

Present law.—A child support obligation assigned to a State as a condition of AFDC eligibility may be released by a discharge in bankruptcy under the Bankruptcy Act.

Committee amendment.—The committee amendment would reverse the effect of an amendment made by section 328 of P.L. 95-598 and reinstate a provision of the Social Security Act, previously in effect, declaring that a child support obligation assigned to a State as a condition of AFDC eligibility is not discharged in bankruptcy. The committee believes that a parent's obligation to support his child is not one that should be allowed to be discharged by filing for bankruptcy, and that a child support obligation assigned to a State as a condition of AFDC eligibility should not be subject to termination in that way.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1982.....	\$17
1983.....	21
1984.....	26

EFFECTIVE DATE

(Section 765 of the Bill)

Amendments and repeals made by the committee are effective October 1, 1981, unless a State agency administering the child support plan demonstrates to the satisfaction of the Secretary of Health and Human Services that it cannot, by reason of State law, comply with the requirements of the committee provisions. The Secretary may prescribe that in such instances an amendment would become effective the first month which begins after the close of the first session of that State's legislature ending on or after October 1, 1981.

H. SUPPLEMENTAL SECURITY INCOME PROVISIONS (PART H OF TITLE VII)

RETROSPECTIVE ACCOUNTING

(Section 771 of the Bill)

Present law.—The Supplemental Security Income (SSI) statute provides for determining a recipient's benefits on the basis of the income anticipated in the calendar quarter. Redeterminations are to be made at such times as provided by the Secretary. There is no provision for regular reporting of changes in income or other factors affecting eligibility.

Committee amendment.—The SSI law would be amended, in a manner comparable to AFDC, to provide that the SSI benefit amount would, in general, be determined on a 1-month retrospective basis, rather than a quarterly prospective basis, as under current law. Eligibility would be determined on the basis of the current month's circumstances. However, for the first month of eligibility (the month in which the application is filed) eligibility and benefit amount would both be determined on a current (prospective) basis.

Special provision is made for the Secretary to waive the limitation on payment to individuals in certain medical institutions in order to facilitate their leaving the institution. To assist in this, the Secretary could allow benefits to be paid in the month the individual leaves the institution and in the preceding month (or 2 months) in an amount appropriate to his new living arrangement. The new procedure would be effective with respect to months after the first calendar quarter which ends more than five months after the month of enactment.

The committee believes that this change from a quarterly prospective system to a monthly retrospective system will help to reduce the number of incorrect payments which are now being made in the SSI program. In the quality assurance measuring period October 1979–March 1980, 12.9 percent of SSI cases involved errors. This resulted in a 5.0 percent payment error rate, or \$185 million in overpayments in that 6-month period. Some of these errors were unavoidable, in that it is not always possible to anticipate changes in income and circumstances. To the extent that benefits will, under the committee amendment, be determined on a retrospective basis, such errors will, in the future, be avoided. Overpayments constitute not only a misuse of Federal funds, but also a serious burden on SSI recipients, who may be called upon to repay benefits which were paid to them in error.

Although the committee bill does not require a regular reporting system for SSI recipients, the committee expects the Social Security Administration (SSA) to make every effort to assure that the payments which it makes are made correctly, and to make sure that recipients know of their responsibility to inform SSA of any changes which could result in an increase or decrease in their SSI benefit. Redeterminations of eligibility should be made on a regular basis.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1983.....	\$30
1982.....	60
1984.....	60

FUNDING OF REHABILITATION SERVICES FOR SSI RECIPIENTS

(Section 772 of the Bill)

Present law.—The Secretary of the Department of Health and Human Services has authority to reimburse State vocational rehabilitation agencies for services provided to blind and disabled recipients of the SSI program.

Committee amendment.—The committee amendment would repeal the authority to reimburse for vocational rehabilitation services. The committee intends that funding for these services will, in the future, be provided as part of a new block grant program.

Estimated savings.—

Fiscal year:	Millions
1981.....	-----
1981.....	\$20
1983.....	18
1984.....	15

I. PROVISIONS RELATED TO SOCIAL SERVICES BLOCK GRANT

(Section 81-99B of the Bill)

Present Law: Social Services.—In addition to providing Federal funding for cash public assistance to certain categories of needy individuals, the welfare titles of the Social Security Act have provided funding for a variety of social services programs. Originally, the costs of social services were considered a part of the administrative costs of operating cash public assistance programs, but subsequent amendments provided separate recognition of social service programs, expanded their availability to persons not receiving cash assistance, permitted funding of services provided by agencies other than the welfare agency itself, and increased the Federal rate of matching from 50 percent to 75 percent.

Under present law, the ceiling on Federal funding for social services under title XX is \$2.9 billion in fiscal year 1981, increasing by \$0.1 billion annually until reaching a level of \$3.3 billion in fiscal year 1985 and thereafter. Of this total, \$200 million in fiscal year 1981 and 8 percent of the total in subsequent fiscal years is available to the States for child day care services with no State matching funds required; the balance of the State's allotment must be matched with the State paying 25 percent of the cost of the services. The present program is an "appropriated entitlement program"—that is, States are entitled to their share of the Federal ceiling, although the funds are in fact appropriated in appropriation bills.

Under present law, States prepare a social services plan which must meet requirements specified in the Federal statute relating to fair hearings, disclosure of information, certain administrative requirements, duration of residency requirements, foster home standards, child day care standards, statewide provision of services, State financial participation, and certain providers of health services. If the State complies with these requirements, the Secretary of Health and Human Services (HHS) must approve the State plan. Title XX also specifies certain requirements a State must meet in developing its

social services plan designed to assure public participation in the plan's development.

Federal day care standards.—A provision was included in the original title XX legislation to require that day care services provided under State social service plans meet the 1968 Federal Interagency Day Care Requirements, with some modifications.

In response to the concern expressed by a number of States that they could not meet certain federal staffing requirements, the Congress enacted temporary legislation delaying their implementation and providing instead that Federally funded day care meet State staffing standards. This temporary legislation was extended several times.

Last year, HHS issued final rules for day care intended to become effective September 19, 1980. The regulations contained requirements concerning a program of activities, health and safety, physical environment, staff training, group composition (including staffing requirements), parent involvement, social services, nutrition, and the role of State agency administration. The Congress was concerned that these Federal day care standards would increase the cost of child care and reduce its availability, particularly for low-income families. In view of these concerns, the Congress precluded implementation of the proposed day care standards until July 1, 1981, allowing an opportunity for Congressional review. In the interim, day care provided with Federal matching funds must meet applicable State and local standards.

Restrictions on use of funds.—States are subject to certain limitations on the use of Federal funds under title XX. The major restrictions are the following:

1. Generally, social service funds cannot be used to pay for medical care, public education, cash payments to individuals, room and board, or for the purchase, construction, or major modification of land, buildings, or fixed equipment.

2. Expenditures used for services to persons receiving or eligible to receive AFDC, Supplemental Security Income (SSI), or Medicaid must be at least equal to 50 percent of the total Federal funding which the State receives.

3. Fees for the social services may be charged individuals or families receiving AFDC or SSI, or whose family income is below the lower of (1) 80 percent of the median income of a family of 4 in the State, or (2) the National median income for a family of 4, only in accordance with rules prescribed by the Secretary of HHS. Except for family planning and certain protective and referral services, fees *must* be charged for social services provided individuals in families whose income exceeds the lower of these two amounts and services may not be provided under the program to families with incomes above 115 percent of the State median income.

4. Federal matching may not be provided for goods or services provided in kind by a private entity, nor for donated private funds (unless the funds are donated to the State without restriction and do not revert to the donor's facility or use).

Present Law: Adoption Assistance and Foster Care

Legislation enacted last year involved a major restructuring of Social Security Act programs for the care of children who must be removed from their own homes. In particular, prior law was modified to lessen the emphasis on foster care placement and to encourage efforts to find permanent homes for children either by making it possible for them to return to their own families or by placing them in adoptive homes.

Subsidized adoptions.—A new subsidized adoption program with Federal matching was established under which a State would be responsible for determining which children in foster care are eligible for adoption assistance because of special needs which have discouraged their adoption. The State has to find that any such child would have been receiving AFDC but for the child's removal from the home of his relatives; that the child cannot be returned to that home; and that, after making a reasonable effort consistent with the child's needs, the child has not been adopted without the offering of financial assistance. The requirement of a search for a nonsubsidized adoptive family does not apply when such a search would be against the best interests of the child.

In the case of any child meeting these requirements, the State may offer adoption assistance to parents who adopt the child. The amount of assistance, to be agreed upon between the parents and the agency, cannot exceed the foster care maintenance payment that would be paid if the child were in a foster family home, and can be readjusted by agreement of the parents and the local agency to reflect any changed circumstances. Adoption assistance payments may be paid until the child reaches 18, or until 21 in the case of a child with a mental or physical handicap.

Effective October 1, 1983, States are required to continue to comply with adoption assistance agreements regardless of whether the adoptive parents are or remain residents of the State.

Children receiving adoption assistance payments are considered to be receiving AFDC and therefore are categorically eligible for Medicaid.

Foster care grants.—Before fiscal year 1981, open-ended Federal matching was provided for foster care payments under AFDC if a child: (1) met State AFDC eligibility requirements and (2) was removed from his home as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare of such child. Last year's legislation set a ceiling on Federal foster care matching funds for 4 years beginning with fiscal year 1981. The ceiling was contingent upon the appropriation of specified additional amounts for the child welfare services program.

Federal funding of foster care maintenance payments is available for children placed in foster care homes, in nonprofit private child care institutions, and in public institutions serving no more than 25 resident children. Federal funding is limited to those items which are comparable to what would be provided in a foster family home such as food, clothing, shelter, personal needs and the costs of providing those items and of supervising the children.

A case plan must be developed for each AFDC foster care child which includes a description of the child's placement and its appropriateness; a plan, if necessary, for compliance with judicial determination requirements; and a plan of services which will be provided. In addition, a case review is required at least every six months by a court of competent jurisdiction or an administrative review.

Child welfare service grants.—The child welfare services program under title IV-B of the Social Security Act provides a Federal contribution to the costs of State programs to protect and promote the welfare of children including the provision of services to enable children to remain in their own homes, action to remove children from unsuitable homes and place them in foster care homes or institutions, and measures to place children in adoptive homes. Within the overall Federal funding available, the Federal matching share is set at 75 percent.

Title IV-B specifically permits expenditures for State tracking and information systems, individual case review systems, services to reunite families or place children in adoption, and procedures to protect the rights of natural parents, children and foster parents.

A State may not receive any IV-B funds in excess of its share of \$141 million unless it has: (1) conducted an inventory of children who have been in foster care for over 6 months; (2) implemented a statewide information system on children in foster care; (3) implemented a case review system for each child in foster care, which includes a 6 month review and 18 month dispositional hearing for each child; and (4) implemented a services program designed to assist children, where possible, to return to their homes. To be eligible to receive its share of increased appropriations under Title IV-B, a State could not reduce its spending level for child welfare services under Title IV-B, below its 1979 level.

When Federal title IV-B appropriations have equaled the authorized maximum of \$266 million for two consecutive years, a State's IV-B funds will be reduced, beginning with the succeeding fiscal year, to the share of \$56 million it received in fiscal year 1979, unless and until it has implemented the protections and procedures described above and, in addition, implemented a service program of preplacement preventive services designed to prevent the need for removing a child from his home.

Committee amendment.—The Committee amendment would repeal the existing provisions of the title XX social services program, the child welfare services program, and the foster care and adoption assistance programs. In place of these provisions, a new title XX social services program would be established on a block grant basis. Within the new title XX, the Committee amendment makes special provision for child welfare, adoption assistance, and foster care so as to assure that States, in operating the new block grant program, will achieve the objectives of those programs as amended by the Adoption Assistance and Child Welfare Act of 1980.

The new title XX would provide that each State be entitled to an annual allotment for operating social services programs. For fiscal year 1982 and each year thereafter, the amount of the allotment for

each State would be its share of a national total of \$2.639 billion. This represents 75 percent of the fiscal year 1981 funding level for the following programs:

[In millions of dollars]

	1981 level	75 percent of 1981
Title XX social services (including child care)--	2, 916	2, 187
Title XX training-----	75	56
Child welfare services and training-----	169	127
Foster care and adoption assistance-----	359	269
Total-----	3, 519	2, 639

The amount allotted to each State would be based on the State's relative share of the Federal funding for these programs in fiscal year 1981. As under existing law, the program would operate as an appropriated entitlement in which the Federal Government is obligated to appropriate an amount sufficient to meet all qualified State expenditures up to the amount of the State allotment. Under the committee amendment, there would be no non-Federal matching requirement and States would be able to claim funds within their allotments for expenditures in the fiscal year to which the allotment applies or in the following year. As under present law, unexpended funds would not be reallocated. However, each State would be authorized to transfer up to 10 percent of its annual title XX allotment for expenditure under health, energy, or emergency assistance block grant programs.

Before expending funds under the new title XX program for any fiscal year, States would be required to develop, transmit to the Secretary of HHS, and make public a report on how the funds are to be used, including information about the types of activities to be funded and the characteristics of the individuals who will be served. This report would be revised throughout the year, as necessary.

Each State would, as under present law, determine the types of services to be provided. Unlike present law, there would be no requirement that a specific portion of the funds be used for welfare recipients. The committee amendments would also eliminate the present law provisions limiting eligibility to individuals with incomes below 115 percent of State median income. The committee amendment prohibits the use of title XX funds for the following specified purposes:

1. The purchase or improvement of land or buildings,
2. Room and board costs (except for certain short-term or emergency shelter or as provided for under the foster care and adoption assistance provisions),
3. Wage payments other than payments under the provisions for subsidizing the costs of hiring welfare recipients in child care jobs; (provisions under present law retained by the committee amendment);

4. Medical care (except where it is an integral part of another service or is provided for initial detoxification of an alcoholic or drug dependent individual),

5. Institutional services (provided by the institution) except for rehabilitation services or services for alcoholic or drug dependent individuals,

6. Educational services which are generally available, and

7. Services in the form of cash payments.

The committee amendment would allow the Secretary of Health and Human Services to waive the prohibition against medical services and against the purchase or improvement of land or buildings where he finds extraordinary circumstances justify such uses.

The committee amendment would eliminate Federal standards for child care services provided under title XX, substituting a requirement that such services be provided in compliance with applicable State and local laws. This is the same requirement that is now in effect under temporary legislation.

Under the committee amendment, States would be required at least every 2 years to prepare, transmit to the Secretary of HHS, and make available reports showing in detail how the program funds were expended and demonstrating that such expenditures meet the requirements of title XX. While each State would determine the exact format and content of its report, consistent with the requirements of this provision, these reports would be the major source of national data on services provided under this program. The committee expects that HHS will provide necessary technical assistance in developing appropriate definitions and categories of services to facilitate this objective. In addition, States would be required to audit their programs at least every 2 years (with the audit being conducted by an entity which does not receive title XX funds). Any amounts expended which did not comply with title XX requirements would be recovered by the Federal Government.

Under present law, social services in territorial jurisdictions are not funded under title XX but under separate authority in several different titles of the Social Security Act. The Committee bill would instead make the new title XX block grant program applicable in the Guam, Puerto Rico, the Northern Mariana Islands, and the Virgin Islands.

Adoption assistance, foster care, and child welfare services.—The Committee bill would provide a separate identification within the overall block grant for programs of adoption assistance, foster care, and child welfare services. The amount of funding under the block grant for any State would be reduced for any fiscal year in which it does not have these programs or does not operate them in accord with the requirements of present law. (This rule would be applied to include requirements of present law which were contingent upon the appropriation of certain specified sums for the child welfare services program.) If a State does not meet these requirements, the amount of reduction in its title XX block grant funds would be that percentage of its allocation for the year in question which equals the funds it received for fiscal year 1981 for AFDC foster care, adoption assistance, and child welfare services as a percentage of the funds it received for those three programs plus title XX social services.

To establish that a State is eligible for the funding associated with the foster care, adoption assistance, and child welfare services portion of the block grant funding, the Governor of the State would be required to certify that the State has a program which complies with the present law provisions and includes (to the extent required by those provisions):

1. A services program designed to help children, whose custody the State would otherwise be required to assume, remain, if appropriate, in their homes;

2. A system in which, for each child for whose custody the State is responsible, a plan is prepared (and subjected to periodic court or administrative review) that is designed—

- (A) to achieve placement in the least restrictive (most family-like) setting available, or a return to the child's own home, or an adoption placement, as appropriate;

- (B) to ensure that the child receives proper care;

- (C) in the case of a foster care placement, to ensure periodic hearings by a court (or agency approved by the court) to review or determine the placement then in the best interests of the child, and

- (D) in the case of a foster care placement, to provide services to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care;

3. Adoption assistance for children with special needs;

4. Methods for establishing, and periodically reviewing, standards for foster family homes and child care institutions designed to ensure appropriate care; and

5. A statewide information system, to be implemented by October 1, 1983, from which the status, demographic characteristics, location, and goals for the placement of every child who is in foster care, or who has been in such care within the preceding twelve months, can readily be determined.

Present law requires these elements as a condition of State participation in the existing law programs. Some of these requirements, such as the offering of adoption assistance, are now provided for on an absolute basis as a condition of Federal funding under AFDC while others, such as the establishment of tracking systems, are required for the receipt of certain amounts of child welfare services funding and are contingent upon specified amounts being appropriated for that program. The committee amendment would make the meeting of these requirements a condition of receiving that part of the title XX block grant which, on a proportional basis, reflects previous funding levels for the three elements of foster care, adoption assistance, and child welfare services.

To the extent that any requirements were contingent upon appropriations levels, the committee amendment would be applied as though the contingencies had been met. However, they would be considered to have become requirements only when a State would have been subject to a loss of funding under present law. In other words, States

would have the same opportunity as under present law to phase into compliance without facing a loss of funding.

Prior to fiscal year 1985, States would need to have in effect a foster care and adoption assistance program which meets the specification of the present title IV-E. Beginning in fiscal year 1985, States would have to meet the various requirements relating to foster care tracking, case review, and pre- and post-placement services in order to continue receiving this segment of their title XX block grant funds. In order to have such a program fully operational by that deadline, States would find it necessary to phase into compliance between the enactment of this legislation and the start of fiscal year 1985.

Under the Committee amendment, States would be required to expend for foster care, child welfare services, and adoption assistance at least 75 percent of the amount they were allotted for these programs in fiscal year 1981. However, foster care payments could not represent a greater proportion of a State's total title XX block grant expenditures than such payments in 1981 represented of the State's total allotment under the foster care, child welfare services, adoption assistance, and social services programs. As under present law, States could not provide foster care payments for children in public institutions which serve more than 25 children.

The annual or biennial State reports on and audits of activities under the title XX block grant would be required to verify that the provisions relating to child care services, foster care, and adoption assistance were complied with.

Under the Committee amendment, the Secretary of Health and Human Services would be directed to conduct a study to identify such criteria and mechanisms as may be useful for the States to assess the effectiveness and efficiency of the service programs under the block grant. The study would include consideration of Federal incentive payments as an option to reward high performance of the States in the services programs. The Secretary would report to the Congress the results of this study within 1 year after the provision is enacted.

It is the committee's belief that the block grant approach is desirable in order to eliminate burdensome restrictions on programs and to give the States the increased flexibility they need to target resources on problems which they regard as most important. While holding to this basic philosophy, it is also the committee's intent that States maintain adoption assistance, foster care and child welfare programs. These programs were only recently established as part of the Adoption Assistance and Child Welfare Act of 1980, and have not yet been fully implemented by States. It is the committee's belief, therefore, that the child welfare, foster care and adoption assistance programs should receive special protection and delineation in the block grant.

J. TRADE ADJUSTMENT ASSISTANCE

(Section J of the Bill)

Present Law.—Under present law a group of workers, their certified or recognized union, or other authorized representative may petition the Secretary of Labor for a certification of eligibility for worker adjustment assistance.

Workers are certified as eligible for worker adjustment assistance if they meet the following conditions: (1) a significant number or proportion of the workers in the workers' firm or appropriate subdivision of the firm have been threatened with or have experienced total or partial separation; (2) the sales or production of the firm or subdivision has decreased absolutely; and (3) increases in imports of "articles like or directly competitive" with articles produced by the workers' firm or appropriate subdivision of their firm "contributed importantly" to threatened or actual total or partial job separation and to a decline in sales or production.

The Secretary of Labor is required to determine whether a group of workers is eligible for adjustment assistance and to issue a certification of eligibility to apply for assistance within 60 days after the petition is filed. The Department has not, however, met this requirement in the last year.

The basic program benefit for workers under the TAA program is the payment of a trade readjustment allowance (TRA). TRA is payable to an adversely affected worker for a week of unemployment and is required to be 70 percent of his previous average weekly wage, not to exceed the average weekly manufacturing wage (now \$289 per week). The weekly TRA payable is reduced by: (1) 50 percent of earnings during the week; (2) any training allowance except that the TRA is required to be paid in an amount at least equal to—and in lieu of—any Federal training allowance; and (3) unemployment compensation for which the individual is eligible. The combined value of any wages, TRA, training allowances and unemployment compensation may not exceed 80 percent of his previous average weekly wage and 130 percent of the average weekly manufacturing wage.

Payments of TRA are required to be made to a certified and eligible adversely affected worker who files an application for any week of unemployment after the "trade-impact date" (the date on which threatened or actual total or partial separation began in the firm or appropriate subdivision of the firm) if the following two conditions are met: (1) the worker's last separation took place on or after the trade impact date but not after the termination date (if any) and not after the expiration date. (The termination date is the date as of which the Secretary of Labor determines the group eligibility conditions are no longer met; the expiration date is two years from the certification date.) (2) the worker had at least 26 weeks of employment at wages of at least \$30 per week in adversely affected employment with a single firm or subdivision of a firm in the 1-year period preceding unemployment.

The maximum number of weeks that TRA can be paid is 78, or one and a half years. The maximum for most workers is 52 weeks. Two sets of workers are eligible for an additional 26 weeks: (1) workers enrolled in training approved by the Secretary of Labor; and (2) workers who are at least 60 years old on or before their date of separation. Except for the additional 26 weeks, TRA may not be paid for a week of unemployment beginning more than 2 years after the most recent separation date. The availability for work and disqualification provisions of State unemployment compensation laws apply to workers filing claims for TRA.

In addition to the TRA benefit, the Secretary of Labor is directed to make "every reasonable effort" to secure counseling, testing, placement, supportive, and other services under any other Federal law. If the Secretary of Labor determines that there is no suitable employment available and suitable employment would be available if the adversely affected worker received the appropriate training, the Secretary may approve such training. Further, a job search allowance providing a reimbursement of 80 percent of the cost of necessary job search expenses not to exceed \$500 may be granted to certified, adversely affected workers for securing a job in the United States if: (1) the Secretary of Labor determines that the worker cannot reasonably be expected to secure suitable employment in his commuting area; (2) the worker has filed an application for the allowance no later than 1 year after the date of his last separation before his application or within a reasonable period of time after a training period. Also, a relocation allowance of 80 percent of reasonable and necessary expenses incurred in transporting a worker, his family, and household effects and an amount equal to three times the worker's average weekly wage up to \$500 may be granted to not more than one member per family.

The program clearly has not functioned as intended. In a study released in January 1980 the General Accounting Office found that the weekly TRA cash payments have helped very few unemployed workers adjust to their changed circumstances. Of the TRA recipients interviewed, 85 percent had returned to work, 67 percent for the same employer who laid them off. Most had received their TRA payments in the form of a lump sum after they had returned to work but had not experienced economic hardship as a result of their lay-off since they were able to rely on their unemployment benefit and other resources to meet their financial needs. Among the causes of the delays in TRA payments is the complicated formula for calculating weekly benefit amounts. Many labor regional, State and local employment security agency and firm officials believe the trade benefits, which in many cases are well above State unemployment insurance levels, create a disincentive for some to seek a job. Seventy-three percent of those surveyed used none of the employment services, job search and relocation allowances because they were not aware the services were available to them, they had little need for the services, and they were not willing to move to take advantage of a job in another community.

Committee bill.—The bill approved by the committee would make the following changes to the present law:

1. Require a worker to exhaust all unemployment insurance (UI) before receiving TRA allowances;
2. Limit the amount of TRA allowances and UI payments for most workers to 52 times the UI weekly benefit, except that an additional 26 weeks of allowances may be paid to an individual engaged in training;
3. Limit the amount of TRA payments to the level of State UI payments for which the individual is eligible;
4. Require increased efforts by beneficiaries to obtain appropriate work;

5. Incorporate certain provisions of State unemployment insurance laws for the purpose of facilitating the administration of the program;

6. Change the present "contribute importantly" standard for trade impact certifications to require that increased imports of like or directly competitive articles be a "substantial cause" of the adverse impact and add to the group eligibility requirements that there is a substantial probability that the resulting lower level of employment will be permanent; and

7. Broaden the present authority to recover overpayments and deny benefits in the case of fraudulent statements or intentional withholding of information.

In addition to integrating the TAA program with the State unemployment compensation system, the committee has proposed changes which would strengthen the training, job search, and relocation aspects of the program proposals. There is no change under the bill in the Secretary's training authorities under section 236 of the Trade Act but the Administration in presenting the bill to the Congress announced that it intends to spend approximately \$100 million more on training for adversely affected workers in fiscal year 1982 than in fiscal year 1981.

Section 1 of the bill would change the "contribute importantly" standard for adverse trade impact certification and require that instead increased imports of like or directly competitive articles be a "substantial cause" of the adverse impact on employment and production. Substantial cause would be defined as a cause which is important and not less than any other cause. This would be the same causation standard as that used by the International Trade Commission (ITC) under section 201 of the Trade Act. This standard would increase the impact of foreign trade required for petition certifications. This provision would assure that the trade-impact is sufficient to warrant such additional benefits provided by the TAA program. The bill also requires that the Secretary before making a certification must find that there is a "substantial probability" that the resulting lower level of employment at the firm or subdivision will be permanent. Because the substantial cause test would be applied to the impact of imports on the *firm*, the Secretary of Labor would be able to certify workers from injured firms in industries even where the ITC did not find injury to the industry as a whole under section 201.

Section 2 of the bill would substantially eliminate retroactive payments by limiting payments to weeks of unemployment which begin more than 60 days after the date an approved petition for certification was filed. The provision would also require adversely affected workers to exhaust all rights to unemployment compensation, and additional compensation and any extended benefits if applicable. Third, workers would not be paid TRA for any waiting week period as provided by any State law.

The provision would also adopt the work test of the Federal-State Extended Unemployment Compensation Act of 1970, as amended, (EB). The EB work test requires that claimants whose prospects of returning to their line of work are not good will be disqualified if they

fail or refuse to accept offers of "suitable work" as defined in that act, or to seek and apply for such work. The EB work test will apply to all claimants for UI after the end of the regular UI period. Therefore, applying the EB work test to all TRA claimants would be an equitable extension of the test which is already applicable to those TRA claimants in States which have triggered "on" an extended benefit period.

The section also provides that the Secretary by regulation may require appropriate categories of workers, who have been eligible for TRA for eight weeks, to extend their job search or to accept approved training.

Section 3 of the bill would limit the amount of TRA payable to a worker to the same amount as the UI weekly amount payable to that worker for a week of unemployment. From the TRA there would be deducted any training allowance provided under any Federal law as well as any income that is deducted from UI under the applicable State UI law. The proposed change will achieve a greater equity between those who are unemployed as a result of trade impact and those unemployed for other reasons.

Section 4 of the bill would limit TRA payable to an adversely affected worker to the amount which is 52 times the UI weekly benefit amount reduced by any UI payable to the worker. Thus, an adversely affected worker could only collect the weekly benefit amount of UI and TRA combined for 52 weeks of total unemployment. An adversely affected worker would also be required to exhaust TRA within 52 weeks after the worker had exhausted all rights to regular unemployment compensation. Payments as TRA would continue to be made to a worker in approved training for up to 26 additional weeks in the 26-week period following the worker's last entitlement to TRA in order to assist the worker to complete approved training. Finally, the worker would be required to have made an application for training within 210 days after the date of the worker's first certification, or, if later, within 210 days after the worker's first total or partial separation.

The payment of TRA is intended to assist unemployed workers to readjust to existing economic circumstances. The bill would better accomplish this purpose by encouraging unemployed workers to seek other employment by appropriately limiting the duration, and the maximum amount of benefits.

Section 5 of the bill would increase the job search allowances for totally separated workers who are seeking suitable employment outside of their area of residence from the present payment of 80 percent of job search expenses up to a maximum of \$500 to a maximum of \$600.

Section 6 of the bill would increase the relocation allowances for totally separated workers who have obtained employment or a bona fide offer of such employment in an area to which they wish to relocate from the present current allowable payment of up to 80 percent of the expenses for relocation and a lump-sum payment in the maximum amount of \$500 to 90 percent of reasonable and necessary expenses and a lump sum payment to a maximum of \$600.

Section 7 of the bill broadens the present provisions relating to the recovery of overpayment made to claimants and provides for waivers where equitable. It provides for recovery of overpayment whether

fraudulent or otherwise. Overpayments may be recovered from benefits under this Act, unemployment compensation or other unemployment assistance or allowances payable to the worker. It denies benefits in the case of fraudulent statements or the intentional withholding of information.

Section 8 of the bill would delete the present authorization section relating to a trust fund since such a fund has not been established. In place of that section the bill provides for an authorization of appropriations for each of fiscal years 1982, 1983 and 1984, such sums as may be necessary to carry out the purposes of the act.

Section 9 of the bill would make necessary definitional changes.

Section 10 of the bill extends the termination date of the worker trade adjustment assistance program from the present termination date of September 30, 1982 to September 30, 1984.

Section 11 of the bill sets forth the effective dates of the various provisions. The amendment with respect to authorization of appropriations would take effect on the date of enactment. The "substantial cause" standard would also take effect for all petitions filed on or after the date of enactment. The increases in job search and relocation allowances would take effect with regard to applications for allowances filed on or after October 1, 1981. The provision regarding recovery of overpayments and penalties for fraud would take effect on the date of enactment. The remaining provisions, which affect the time limitations on trade readjustment allowances, definitions, qualifying requirements and the weekly benefit amounts, would be effective with respect to trade readjustment allowances payable for all weeks of unemployment which begin after October 1, 1981. The section also provides transitional provisions to ensure that workers receiving TRA payments are not disqualified from receiving further payments to which they would otherwise be entitled by reason of the application of the changes made by the bill after September 30, 1981.

III. REGULATORY IMPACT OF FINANCE COMMITTEE AMENDMENTS

In conformance with paragraph 11(b) of rule XXVI of Standing Rules of the Senate the following Finance Committee evaluation is made of the regulatory impact which would be incurred in carrying out title VII of the bill.

A. SOCIAL SECURITY PROVISIONS

The sections in part A of title VII of the bill modify a number of aspects of the social security program. Section 1 which phases out the student benefit, would lessen regulatory requirements and paperwork burden for the public by reducing the need to report on school enrollment. Benefits for secondary students between the ages of 18 and 19 would be predicated on school attendance, but reporting requirements should be substantially the same as now. The percentage reductions in the amount of benefits allowed during the phase-out period and the elimination of summer month benefits should not add to current paperwork requirements for students.

Section 2 which eliminates the minimum benefit for present and future beneficiaries, would have major regulatory and administrative impacts. Benefit amounts would have to be recalculated for some 3 million current beneficiaries, and the methods for those recalculations would be stipulated in regulations. It is probable that some of those beneficiaries as well as some future beneficiaries would be asked for additional information about their prior work history and earnings. There also would be additional impact because of the provision to provide minimum beneficiaries aged 60-64 with special SSI payments. In return, however, they would be protected from losing income clearly necessary to their financial support.

Section 3, restricting lump-sum death payments, would decrease the regulatory burden and paperwork for the public. Under present law, if there is no surviving spouse, the payment can be made to a funeral home, to the estate, or to individuals who assumed responsibility for burial expenses. The process of determining who was entitled to the payment (and the proportional shares, if there were several individuals involved) would be eliminated. The payment would be made automatically to a surviving spouse or dependent who was eligible for monthly benefits. Once the death was reported, the Social Security Administration (SSA) could in most cases make the payment without obtaining any other additional information.

Section 4, which requires newly disabled beneficiaries to have worked in covered employment in 6 of 13 calendar quarters preceding the onset of disability, would increase regulatory requirements. The SSA may not have sufficiently recent earnings information to determine whether the requirement had been met. The paperwork burden for applicants or former employers who may be asked for the needed information would thereby be increased. Consistent with committee intent, persons who could not meet the stricter requirements would not be eligible for benefits.

The extension of the worker's compensation offset to include certain other disability benefits, in Section 5, would have a regulatory and economic impact on future beneficiaries of disability insurance who become eligible for other types of disability benefits. Disabled workers would be responsible for reporting the other benefits received, and the SSA would have to calculate the appropriate offset for more cases than at present. The provisions to apply the offset to those aged 62-64 and to begin the offset with the month of payment of the other benefit (rather than the month notice is received) should affect regulatory requirements imposed on beneficiaries in only a minor way, but would reduce benefits payable. Regulatory requirements for State and local governments and other Federal agencies would increase to the extent that they were asked to provide information on disability benefits payable.

The provision to eliminate trust fund reimbursement for vocational rehabilitation (VR) services, in section 6, would significantly decrease regulatory impact on State and local agencies which currently administer the program. Only regulatory requirements relating to other VR programs which began serving those beneficiaries would have to be met (and such other requirements would be reduced under the block grant approach). Section 7, which provides for reimbursement of Pension

Reform Act costs would have no regulatory impact; pension plans requesting information would be asked for full reimbursement of the costs of providing requested information. The provision to round benefits, section 8, would not have significant regulatory impact; it would result in slightly lower benefit amounts.

The social security provisions (except Pension Reform Act cost reimbursement) would have economic impact on certain beneficiaries in the form of lower benefit amounts, benefits that would not be paid because eligibility requirements would not be met, or services that may no longer be available. There would be substantial tax savings for workers covered by social security.

B. MEDICARE PROVISIONS

In implementing certain cost saving provisions of Part B of the bill there will be some increase in Federal regulatory activity. It is not anticipated, however, that the legislation would impose an unusual or burdensome regulatory effect. Several provisions will, in fact, decrease regulatory activity and associated paperwork.

Section 20A which authorizes payments to promote closing and conversion of underutilized facilities establishes a new procedure that would require implementing regulations, as would section 20B which requires the calculation of statewide median charges for physician services. Section 20C would require the promulgation of new regulations establishing limits on the reasonable cost and charges for outpatient hospital services.

Section 20H which requires coordination of benefits between the Medicare program and certain other health insurance policies or plans will generate new regulatory activity in order to implement this significant change in program policy.

Provisions of Part B that will decrease Federal regulations and resulting paperwork include provision which eliminate: the need for occupational therapy as a basis for entitlement to home health services, (2) Part A coverage for alcohol detoxification facility services, (3) certain dental coverage, (4) unlimited open enrollment, and (5) coverage of pneumococcal vaccine.

C. MEDICAID PROVISIONS

In general, the provisions of Part C of the bill will decrease federal regulatory activity. Although, the federal cap on medicaid expenditures is a new requirement, the percentage increase or decrease each State's cap, beginning with fiscal year 1983, will be based on the GNP Implicit Price Deflator for such fiscal year, a measure which is currently published by the Department of Commerce. This new calculation is not expected to place any significant federal regulatory burden on the States.

A number of provisions of Part C are clearly expected to reduce the federal regulatory impact including those which permit States to enter into cost-effective service arrangements and those which permit States flexibility in determining reasonably cost-related payment rates for hospitals.

D. MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDRENS PROVISIONS

Part D of the bill would replace the existing maternal and child health program under title V with a new maternal and child health block grant that would incorporate title V services and certain other services currently authorized under the Public Health Service Act. The impact of this proposal would be to substantially reduce the regulatory and paperwork requirements of the existing programs.

E. UNEMPLOYMENT COMPENSATION PROVISIONS

The sections in part E of title VII of the bill modify a number of aspects of the unemployment compensation programs. Sections 41, 42, and 43, dealing with extended benefit trigger levels, should reduce the Federal regulatory impact on the States inasmuch as they increase State flexibility by removing an existing-law mandatory provision and decrease the frequency with which States find it necessary to operate the extended benefits program under modification to the remaining trigger provisions. Ultimately the economic impact of these provisions is likely to be a reduction in the unemployment tax burden on employers reflecting a similar reduction in benefits to individuals. The level of this impact is indicated in the budgetary impact section of this report.

Section 44 establishes certain new limits on the payment of extended unemployment compensation benefits. As such, the provision can be expected to (and is intended to) have an impact on individuals who would otherwise receive benefits under this program. However, those affected would be a relatively small proportion of the total population of extended benefit recipients. The implementation of this provision will involve some regulatory impact on applicants and on the State agencies that administer the program inasmuch as this provision will require somewhat different eligibility rules for the extended benefit program than those that apply to the regular program (except to the extent that States choose to implement these rules in their regular programs). However, the regulatory impact is not expected to be excessive since States already receive information concerning the prior wage history of applicants.

Section 45 disqualifies exservicemembers who voluntarily leave the military from receiving unemployment compensation. This provision will reduce the paperwork involved in processing claims and computing the Federal fiscal liability for such individuals.

Section 46 changes the conditions under which States may obtain loans from the Federal Government to finance unemployment compensation benefits by charging interest on all new advances and placing certain limits on the increase in the Federal unemployment tax rate in debtor States. These provisions will have no regulatory impact on the States, but the U.S. Department of Labor will be required to determine whether debtor States satisfy a solvency test in order to qualify for a cap on the increase in the Federal unemployment tax rate. States must raise revenue to pay the interest charge. Employers in debtor States qualifying for a cap on the increase in the Federal unemployment tax rate will benefit from lower Federal unemployment taxes.

Some additional paperwork will be involved in the administration of the solvency test by the U.S. Department of Labor, but the committee expects that it will be minimal.

States must enact provisions in their State unemployment compensation laws conforming to these provisions. To obtain approval of their programs from the Secretary of Labor, section 47 provides a reasonable time period for all States to comply with the provisions in sections 41 through 44.

F. AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROVISIONS

The sections in part F of title VII of the bill modify a number of aspects of the AFDC program. The economic impact of sections 51, 52, 54, 55, 56, 60F, 60H, and 60E is likely to be a reduction in benefits for certain recipients. This is the committee's intent as it endeavors to target AFDC expenditures on those most in need. With the exception of section 51 which deals with the earned income disregard, the proportion of recipients experiencing reduced benefits will be relatively small. Sections 52, 53, 60, and 60A-D deal with eligibility for benefits and should not lead to any new paperwork or increase in administrative costs. The economic impact of this group of provisions will be a reduction in tax burden.

The committee expects that the provisions concerning the earnings of AFDC recipients, lump sum payments to AFDC recipients, and advance payment of the earned income tax credit will have relatively little regulatory impact on recipients, applicants, or the State and county agencies that administer the program. These provisions only change the order or timing of recipients' income in determining their benefit amount. The provisions to standardize the earnings disregard simplify administration and should reduce the incidence of erroneous payments.

The regulatory impact of AFDC on recipients and on State and county agencies could increase should a State choose to implement one or more of the provisions related to employment of AFDC recipients. It would be necessary to find jobs for eligible recipients; determine hours of work; determine benefit amounts, if any; and make contractual agreements with employers. In return, however, States would be given substantially more flexibility. The committee does not expect the employment provisions to result in a significant number of new regulations.

Monthly reporting and retrospective accounting will increase the regulatory impact of AFDC on the State and county agencies that administer the program because considerably more paper work will be needed. The committee expects, however, that the net effect of the provision will be to greatly reduce the number of overpayments and underpayments.

G. CHILD SUPPORT ENFORCEMENT PROVISIONS

The child support enforcement provisions should have minimal regulatory effect. The committee understands and expects that the provision requiring the IRS to withhold tax refunds of persons owing delinquent child support payments will be administered in such a way as to strictly limit the administrative burden of the IRS.

H. SUPPLEMENTAL SECURITY INCOME PROVISIONS

Retrospective accounting for SSI recipients should reduce the regulatory impact on affected individuals as the committee expects the number of overpayments (and underpayments) to be reduced. The provision also calls for prospective budgeting to be used in the first month after application to prevent hardship and in the final month to prevent payment of benefits to those whose circumstances have changed and who thus no longer meet the needs requirements. This provision should simplify administration.

I. SOCIAL SERVICES BLOCK GRANT PROVISIONS

The committee bill would replace the existing social services program under title XX of the Social Security Act with a new Social Services Block Grant that would incorporate title XX social services, day care, social services training, foster care, adoption assistance, child welfare services and child welfare training. Existing portions of the Social Security Act related to child welfare services, foster care and adoption assistance would be repealed by the committee bill. The impact of this proposal would be to reduce substantially the regulatory and paperwork requirements currently imposed on States by each of the existing programs. Federal day care requirements, which under current law would apply to title XX-funded day care as of July 1981, would not apply to day care financed under the block grant. Day care provided under the block grant program instead would be subject to applicable State and local standards.

J. TRADE ADJUSTMENT ASSISTANCE

The committee states that the trade adjustment assistance provisions of the committee bill will not regulate any individuals or businesses, will not impact on the personal privacy of individuals, and will result in no additional paperwork.

IV. BUDGETARY IMPACT OF THE FINANCE COMMITTEE AMENDMENTS

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate and with sections 308 and 403 of the Congressional Budget Act of 1974, are the following statements made relative to the budgetary impact of the Finance Committee amendments included in title VII of the bill. The committee accepts as its estimates the report of the Congressional Budget Office under section 202 of the Congressional Budget Act, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., June 5, 1981.

HON. ROBERT DOLE,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 202 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimates of the bill for reducing spending in pro-

grams within the jurisdiction of the Senate Committee on Finance. These estimates cover the provisions that affect Social Security, SSI, unemployment insurance, trade adjustment assistance and social services. Estimates of provisions affecting primarily Medicare and Medicaid will be forwarded under separate cover as soon as they are completed.*

The estimates included in the attached report represent the 1981-1986 effects on the federal budget of the Committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimates.

Sincerely,

ALICE M. RIVLIN,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE, JUNE 5, 1981

1. Bill title: Provisions Reducing Spending in Programs Within Jurisdiction of Senate Committee on Finance.

2. Bill status: As ordered sent to the Senate Budget Committee by the Senate Committee on Finance on May 5, 1981.

3. Bill purpose: To bring the expenditures authorized by the Senate Committee on Finance within the reconciliation target for that Committee established by the Congress.

4. Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	-123	-2,986	-2,502	-1,148	-316	99
Authorization level.....	0	-1,013	-1,186	-1,339	-20	-20
Revenues.....	10	207	356	405	0	0
Outlays.....	-317	-7,054	-7,817	-8,172	-7,107	-7,653

The savings resulting from this bill fall within budget functions 550 and 600.

5. Basis of estimate: The basis of estimate statements are included under each section. This estimate covers provisions which affect Social Security, SSI, Unemployment Insurance, Trade Adjustment Assistance and Social Services. Estimates of provisions affecting primarily Medicare and Medicaid will be forthcoming under separate cover. The section numbers were determined from a draft of the bill, and may not match those in the final version of the bill in all cases.

6. Estimate comparison: None.

7. Previous CBO estimate: Where applicable, previous CBO estimates are discussed by section under "Basis of Estimate."

8. Estimate prepared by: Human Resources Cost Estimates Unit, Charles Seagrave, Al Peden, Steve Chaikind, Dick Hendrix (225-7766).

9. Estimate approved by:

C. G. NUCKOLS
(For James L. Blum,
Assistant Director for Budget Analysis).

*The additional estimates, subsequently received, follow this report.

SOCIAL SECURITY

Section 1: Eliminate Student Benefits for Post-secondary Students.
Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	0	21	102	243	419	621
Outlays.....	0	-567	-1,580	-2,033	-2,225	-2,401

Basis of estimate: This provision will phase out post-secondary Social Security student benefits over four years for 18 to 22 year olds beginning in July 1982. It also affects those already on the rolls by terminating future cost-of-living adjustments after the 1981 adjustment, and by ceasing benefit payments for four summer months. The provision, in addition, further reduces benefit amounts for those remaining on the rolls by 25 percent each year beginning in August 1982. High school students aged 19 or over will also lose all benefits under this provision.

CBO's estimate of this proposal is based on payments accruing to slightly more than 600,000 post-secondary students. The average monthly benefit for these students in July of 1981 would be approximately \$255 under current law. These overall estimates exclude amounts going to high school students under age 19 and are offset by higher benefits to other family members that could result from this provision.

The savings to Social Security could be offset by increased aid from other educational programs—notably from the Pell Grants (BEOGS) program. Reductions in Social Security benefits would mean that more post-secondary students could meet the Pell Grant income test, thereby potentially increasing the number of Pell Grant applicants. These offsets are not included in the savings estimates given here, but are estimated to be approximately \$25 million in 1982, \$40 million in 1983 and \$45 million each year thereafter, depending on the amounts ultimately appropriated for Pell Grants.

Section 2: Eliminate the Social Security Minimum Benefit.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
OASDI:						
Budget authority.....	2	53	157	275	407	578
Outlays.....	-60	-1,300	-1,400	-1,500	-1,500	-1,500
SSI:						
Budget authority.....	10	330	330	430	430	430
Outlays.....	10	330	330	430	430	430
Total:						
Budget authority.....	12	383	487	705	837	7,008
Outlays.....	-50	-970	-1,070	-1,070	-1,070	-1,070

Basis of estimate: This provision would reduce the minimum benefit for approximately 2 million current OASI recipients, as well as for newly awarded beneficiaries. The average benefit for these groups will be reduced by approximately 40 to 50 percent beginning August 1981.

CBO concurs with the Administration's estimate of Social Security outlay reductions. These estimates are offset by increased assistance payments—notably SSI benefits—to those in need. The provision also specifically provides a new SSI benefit to those aged 60 to 64 who have their minimum benefit reduced and who meet the SSI eligibility criteria. These offsets to Social Security savings are included in the estimates given here, and are estimated to be approximately \$330 million to \$430 million yearly over the 1982 to 1986 period. Offsets in increased SSI benefits to those currently eligible for SSI of \$300 to \$400 million are the Administrations'. The estimate of \$30 million in added SSI costs for those newly entitled to SSI were estimated by CBO. Preliminary data show that approximately 10 percent of all minimum benefits go to those under aged 65. Assuming the same distribution of SSI recipients for those under age 65 as for the population as a whole shows the added SSI cost of this additional provision to be \$30 million, affecting approximately 40,000 recipients.

Section 3: Restrict Payment of OASDI Lump Sum Death Benefits.
Cost estimate:

(By fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985	1986
Budget authority.....	1	9	25	42	61	83
Outlays.....	-17	-200	-210	-215	-220	-230

Basis of estimate: The lump sum death benefit is paid to survivors or the person or institution designated to pay burial expenses. The maximum burial expense is \$255; since this amount has not been increased since 1954, most recipients receive this maximum payment. This provision would eliminate this benefit for all institutions. Surviving spouses or dependents will still get the lump sum death benefit. The Administration estimates that approximately 50 percent of the death benefits go to such families; CBO agrees with this estimate. Thus, approximately half of the 1,400,000 yearly recipients of the benefit would continue to receive it, and \$200 million of the anticipated \$400 million in benefits would be saved. The estimate assumes that the provision will first be implemented for those who would have become entitled to this benefit after July 1981. There are some potential administrative costs and savings to this proposal; it is assumed that these offset each other. Since surviving families will continue to receive this benefit, there are not expected to be any additional costs to federal public welfare programs.

Section 4: Tighten Regency of Work Test for Disability Benefits.
Cost estimate:

(By fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985	1986
OASDI:						
Budget authority.....	0	5	22	59	114	190
Outlays.....	0	-124	-350	-582	-804	-1,008
HI and SMI:						
Budget authority.....	0	0	0	2	10	23
Outlays.....	0	0	0	-47	-138	-236
Total:						
Budget authority.....	0	5	22	61	124	213
Outlays.....	0	-124	-350	-629	-942	-1,244

Basis of estimate: This proposal would require that eligibility for new disability awards be based on a "more recent" work test (6 out of the last 13 quarters, in addition to 20 out of the last 40 quarters as under current law). Studies have shown that approximately 10 percent of disabled workers had worked for one year or less before the onset of disability. This group is assumed to be the one in which most people who would not meet the recency of work requirement would fall.

CBO's baseline estimate assumes 380,000 new DI awards in 1982. After adjusting the estimate for those who would normally be expected to leave the rolls, this provision could save \$124 million in fiscal year 1982 and grow to \$1 billion by 1986 from the DI trust funds. Because people who receive DI payments also receive Medicare benefits after two years, there will be additional savings to the HI and SMI trust funds beginning in 1984.

Section 5: Miscellaneous Disability Changes.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	0	3	12	23	37	55
Outlays.....	-5	-87	-122	-156	-187	-217

Basis of estimate: These provision would limit total payments received by individuals for all forms of disability benefits (except for veterans and private benefits). It would put a "megacap" on the level of earnings replacement for which combined disability benefits may be paid, extend the workers' compensation offset to include workers aged 62 to 64 and start that offset one month sooner.

CBO concurs with the Administration's estimate.

Section 6: Discontinue Trust Fund Financing of Vocational Rehabilitation Services.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	0	3	10	16	23	29
Outlays.....	0	-87	-86	-73	-73	-53

Basis of estimate: CBO has accepted the Social Security Administration's estimate of anticipated payments from the trust funds to the states for providing vocational rehabilitation services. If these payments were terminated beginning with the start of fiscal year 1982, savings would initially equal those amounts. However, recent studies indicate that, after a period of time, vocational rehabilitation is successful in terminating DI recipients from the rolls. At some point, there is a positive return for each vocational rehabilitation dollar spent in the form of reduced benefit payments and higher payroll tax collections. An estimate of these offsets was taken into account over the

estimating period. By the end of the fifth year, it is estimated that there is an average total return of 68 cents for each dollar spent on vocational rehabilitation five years earlier.

By ceasing payments for vocational rehabilitation services, recipients who would have been terminated from DI are not, and thus after two years medicare payments would also continue, subtracting from the savings resulting from the bill. These offsets are thought to be small in the five year period, however, and they would not begin to be felt until fiscal year 1984. They are not taken into account here.

Section 7: Pension Reform Act—Cost Reimbursement.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	0	0	0	0	1	2
Outlays.....	0	-1	-2	-5	-8	-10

Basis of estimate: This provision enables SSA to recover the administrative costs of providing earnings information to private pension plans. CBO concurs with the Administration's estimates.

Section 8: Round Social Security Benefits.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
OASDI:						
Budget authority.....	0	3	15	35	58	85
Outlays.....	-1	-72	-246	-268	-291	-314
Railroad retirement:						
Budget authority.....	0	0	0	1	2	2
Outlays.....	0	-2	-7	-8	-9	-9
Total:						
Budget authority.....	0	3	15	36	60	87
Outlays.....	-1	-74	-253	-276	-300	-323

Basis of estimate: This provision would round all Social Security benefits to the lowest \$1 at the last step of the benefit computation process. Each year, benefits would be based on the primary insurance amount; there would be no compounding of benefits previously rounded down to the lowest \$1. In addition, each step in the benefit computation process would require rounding to the nearest 1 cent; benefits and each computation step are currently rounded to the next higher 10 cents. In the first full year that this provision is in effect, each of the 36 million recipients would have their benefits reduced by approximately 55 cents per month. The estimate assumes that the rounding for those benefits already being paid will first occur in June 1982, the next scheduled date for revising benefit amounts based on increases in the CPI. Benefit computations for new recipients are assumed to follow these rules beginning with awards in July 1981.

The estimate includes the effects this provision will have on the Social Security portion of Railroad Retirement benefits.

UNEMPLOYMENT INSURANCE

Section 41 : Repeal National Trigger.

Cost estimate :

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....		-300				
Outlays.....		-657				

Basis of estimate : Under the economic assumptions agreed upon by the conference on the first budget resolution, the unemployment rate is expected to trigger a national extended benefit program for the first quarter of fiscal year 1982. Elimination of the national trigger will therefore have a savings impact in this year.

Estimate comparison : Under the Administration's economic assumptions, unemployment rates in 1981 were expected to trigger the national extended benefit program. Under current economic assumptions, no national trigger is anticipated in fiscal year 1981; therefore, no 1981 savings are shown from repealing the national trigger.

Section 42 : Exclude Extended Benefit Claimants from State Trigger Calculation.

Cost estimate :

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	-100	-400	-600	-100		
Outlays.....	-208	-561	-380	-120	-10	

Basis of estimate : Under current law, recipients of extended benefits are counted in calculating insured unemployment rates, causing state extended benefit programs to trigger on more slowly and remain on longer than would otherwise be the case. This proposal would remove such beneficiaries from the calculation of the rate.

CBO concurs with the Labor Department's savings estimates.

Section 43 : Raise State Triggers to 5 Percent Plus 120 Percent, or 6 Percent.

Cost estimate :

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....			-100		-100	-200
Outlays.....			-92	-72	-270	-284

Basis of estimate : Under current law, extended benefits are payable in a state when, for the most recent 13 week period, the state insured unemployment rate averages at least 4 percent and, in addition, is 20 percent higher than it was during the same 13 week period in the two previous years. When the "20 percent" factor is not met, a state at its option may provide extended benefits when the state in-

cured unemployment rate averages 5 percent. This proposal would raise the state trigger to 5 percent and 120 percent of the rate existing in the comparable period in the two previous years or allow states to provide extended benefits when the state insured unemployment rate reaches 6 percent.

CBO concurs with the Labor Department's savings estimates for this proposal.

Section 44: Require 20 Weeks of Work for Extended Benefits.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....						
Outlays.....			-11	-10	-4	-2

Basis of Estimate: Under current law, states require that an individual must have earned a specified amount of wages or must have worked for a certain period of time within the base period, or both, to qualify for unemployment benefits. The specific qualifying formula varies widely among states, but all have the intent of permitting only those persons with genuine labor force attachment to receive program benefits. This proposal would standardize the qualifying requirement for extended benefits by admitting to program participation only those individuals with 20 weeks of work in their base period.

CBO concurs with the Labor Department's savings estimates for this proposal.

Section 45: Eliminate Benefits for Those Who Voluntarily Quit Military Service.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....	-36	-265	-254	-244	-251	-240
Outlays.....	-36	-265	-254	-244	-251	-240

Basis of estimate: Using detailed Department of Defense data on discharges by reason for discharges, CBO has estimated that this proposal would reduce eligibility by 92 percent. In 1981, the savings are only 12 percent of current base spending because only those discharged after July 1, 1981 are affected.

Estimate comparison: Shown below is DOL's estimate of the budgetary impact of this provision. The differences which exist between the two sets of estimates for fiscal years 1982 through 1986 are a result of differing baseline projections of the current law program.

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Required budget authority.....	-60	-225	-237	-245	-247	-248
Outlays.....	-60	-225	-237	-245	-247	-248

In fiscal year 1981, CBO has estimated a smaller savings than has DOL, since relatively few individuals will be affected.

Section 46: Loan Reform Package.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Revenues/budget authority	9.6	207.0	355.5	404.8	.....	.....
Outlays .....	.....	.....	.....	.....	.....	.....

Basis of estimate: This provision would alter the current system of financing unemployment compensation benefits in two respects. First, to reduce the incentive to borrow to meet benefit payment demands, interest would be charged on all new advances other than those required to meet seasonal cash flow needs. Interest charged at a 10 percent rate would be payable on any advances taken after May 5, 1981, unless such advances were repaid by September 30 of the fiscal year in which the debt was incurred. Such interest charges would be due by the last day of every quarter. A state would be precluded from paying interest from its individual trust fund and from taking any action which would indirectly achieve the objective of paying interest out of its trust fund. Any repayments made by the state would first be credited against the part of loan principal longest outstanding.

Second, employers would be eligible for a freeze on the loss of FUTA tax credit during any year in which the state met a "solvency test." This test stipulates that a state engage in no new net borrowing and that it take no action the net effect of which represents a relaxation of its tax effort or a liberalization of benefits. The freeze would be set at 0.6 percent or the level of credit reduction applicable for the taxable year during which the state met the solvency test, whichever was higher. However, employers in states in which the economy demonstrated a significant improvement, as measured by an insured unemployment rate equal to 80 percent or less of its level for the preceding two years, would be liable for an additional 0.3 percent loss of FUTA tax credit. Conversely, a temporary waiver of the solvency test would be granted to those states which (1) paid extended benefits for at least six months and (2) had a tax rate as a percentage of total wages equal to at least 150 percent of the national average.

The increase in budget authority which would result from these two proposals represents the net of an increase in revenues resulting from the imposition of interest charges and a decrease in revenues following from the freeze on the loss of the FUTA tax credit. The estimate of revenue growth stemming from the charging of interest was calculated by taking forecasts of annual state loan demand provided by the Labor Department (DOL), estimating the quarterly distribution of such loans based upon past experience, and imposing a 10 percent interest rate upon such loans. The estimate of revenue loss resulting from the freeze on the loss of the FUTA tax credit was calculated by taking DOL forecasts of increased FUTA revenue due to the loss in offset credit, determining the year in which states with outstanding

loans would meet the solvency test, and applying the change in tax rates to the respective states' payroll bases. No budgetary impact is shown for fiscal years 1985 and 1986 because the program is scheduled to terminate on September 30, 1984.

Estimate comparison: Shown below is the DOL estimate of the budgetary impact of the provision. It differs from the CBO estimate in fiscal years 1982 and 1983 primarily because of different assumptions regarding the quarterly distribution of loan demand within given years. DOL has assumed all advances will be borrowed within the first two quarters of the fiscal year. CBO has assumed that a certain proportion of borrowing will occur in the final quarter of the fiscal year as well. DOL has made no estimate of budgetary impact in fiscal year 1984.

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Required budget authority.....	9.6	265	446			
Outlays.....						

Provision: Trade Adjustment Assistance—Integrate State Unemployment Compensation Program, Limit Allowances, Strengthen Administration.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Budget authority.....		-1,295	-800	-450		
Outlays.....		-1,295	-800	-450		

Basis of estimate: The estimated savings of this provision are based on a composite distribution of unemployment insurance claimants by length of unemployment and a weighted average of unemployment insurance benefits for those states with the greatest number of trade adjustment assistance claimants. There is no fiscal impact in fiscal years 1985 and 1986 because the program is not authorized beyond fiscal year 1984.

Previous CBO estimate: CBO originally estimated the savings of this provision for the Senate Budget Committee at \$1,335, \$840, and \$475 million for fiscal years 1982, 1983, and 1984, respectively. These estimates were made assuming that no trade adjustment assistance claimant would be able to collect benefits beyond 52 weeks. Since that time, the Administration has developed more details on the provision and the present proposal would permit workers in training to be eligible for benefits for an additional 26 weeks. This has caused the savings estimates to decline.

On May 15, 1981, CBO prepared a cost estimate for S. 1201, as ordered reported by the Senate Finance Committee. The sections of that bill incorporating those provisions contained here have the same estimates of savings.

AID TO FAMILIES WITH DEPENDENT CHILDREN

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Provisions affecting earners, total:					
Budget authority.....	-425	-433	-441	-447	-452
Outlays.....	-425	-433	-441	-447	-452
(a) Limit earnings disregard (sec. 51).....	-206	-212	-218	-222	-226
(b) Limit \$30 plus $\frac{1}{2}$ to 4 mo (sec. 51).....	-168	-172	-177	-181	-184
(c) Count advance payment of EITC (sec. 55).....	-51	-49	-46	-44	-42
(d) Limit eligibility to 150 percent of state needs (sec. 53).....	(1)	(1)	(1)	(1)	(1)
(e) Eliminate payments of under \$10 per month (sec. 60F).....	(1)	(1)	(1)	(1)	(1)

¹ Insignificant.

Basis of estimate: The provision to limit the earnings disregard would standardize the work expense at \$75 per month prorated for part-time or part-month work, cap child care expenses at \$160 per month per child, and apply the disregards in the following order: 1) flat \$30; 2) \$75 (or prorated amount); 3) child care expenses; and 4) one-third of the remaining expenses.

The second provision would limit the application of the earnings incentive formula to four months, after which the AFDC families' benefits would be calculated as their eligibility need determination minus earnings. Since many families with four months of earnings would have earnings in excess of their eligibility needs, they would go off the AFDC rolls.

The third provision would assume advance receipt of the Earned Income Tax Credit (EITC) in computing earned income, even though in fact it may not be received except as an income tax rebate. The last two proposals (d and e) are not expected to have a significant impact on AFDC benefits.

These proposals together are expected to have an impact on approximately one-half million AFDC families who have earnings each month.

The savings shown above assume no labor supply response because of these proposals. This is consistent with the methodology used by the Administration in calculating the expected savings of the Reagan proposals and is consistent with preliminary estimates developed by CBO and given to the Senate Budget Committee for use in the development of reconciliation instructions.

These proposals would, however, increase the work disincentives found in the current AFDC program. Currently AFDC families, on the average, are able to retain about 50 percent of their earned income. Under the proposed changes, AFDC families would be able to retain only about 20 percent of their earned income. CBO is currently developing a methodology to include possible labor supply effects into the savings estimates. Preliminary estimates of possible labor supply responses, show savings only about one third the magnitude of those shown here.

Section 52: Limit Allowable Resources to \$1,000.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-16	-17	-17	-17	-17
Outlays.....	-16	-17	-17	-17	-17

Basis of estimate: This provision would place a limit of \$1,000 per family in allowable equity, but exempt from consideration a home owned and occupied by the family and one motor vehicle. CBO concurs with the Administration's cost estimate for this proposal.

Section 52: Permit States to Take into Account Food Stamp Benefits and Housing Subsidies for AFDC Families.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-100	-103	-105	-108	-110
Outlays.....	-100	-103	-105	-108	-110

Basis of estimate: This proposal would permit states to take into account food stamps and housing subsidies in determining their AFDC benefits. Some states, however, already earmark a portion of the needs standard for food and some make allowances for rent, up to a limit. In addition, an informal CBO survey of states showed little interest in the proposal beyond what states were currently doing. The above cost estimate of \$100 million in savings for fiscal year 1982 is from the Administration.

Section 54: Count Lump-Sum Payments as Income.

Cost estimate:

	1982	1983	1984	1985	1986
Budget authority.....	-5	-5	-5	-5	-5
Outlays.....	-5	-5	-5	-5	-5

Basis of estimate: This provision would require states to consider all lump-sum payments as income available to meet a family's needs. CBO concurs with the Administrations estimate for this proposal.

Section 56: Count Stepparents' Income.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-108	-111	-113	-116	-118
Outlays.....	-108	-111	-113	-116	-118

Basis of estimate: This proposal would require states to count a portion of a stepparent's income in determining the AFDC families' benefit. It specifies that some of the stepparent's income must be reserved for support of his/her own income tax dependents, for pay-

ments of alimony or child support, and for work expenses. More than 100,000 families are expected to be affected by this provision.

CBO's savings estimate of \$108 million in fiscal year 1982 is about two-thirds of the savings estimate made by the Administration. The reduction in savings was due to an assumed break up of some households as a result of the provision.

Section 57: Require Community Work Programs.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	0	-20	-41	-52	-53
Outlays.....	0	-20	-41	-52	-53

Basis of estimate: This provision would require states to establish community work experience programs in which AFDC recipients (subject to certain restrictions) would be required to perform work in exchange for their AFDC check.

The savings estimate shown above is from the Administration. Further investigation by CBO of community work experience programs in Massachusetts, Utah and California has indicated that these savings estimates may be too optimistic.

Section 60: Prohibit Payments to Strikers.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-5	-5	-5	-5	-5
Outlays.....	-5	-5	-5	-5	-5

Basis of estimate: This proposal would amend the Social Security Act to prohibit AFDC payments to a family of a person who participates in a strike during the period of strike participation.

CBO concurs with the Administration's cost estimate.

Section 60A: Eliminate Payments to Children 18 and Over Unless They Are Attending High School.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-100	-104	-108	-111	-113
Outlays.....	-100	-104	-108	-111	-113

Basis of estimate: This provision would amend the definition of "dependent child" to children through age 17, or 18 if the child is in high school during his/her eighteenth year. The above estimate assumes removal from the AFDC roles of two-thirds of families whose youngest child is 18 or older and two-thirds of all dependent children over 18 in other families.

Section 60B: Eliminate Payments to Pregnant Women Before the Sixth Month.

Cost estimate :

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority	-16	-17	-17	-18	-18
Outlays	-16	-17	-17	-18	-18

Basis of estimate : This provision would eliminate payments to pregnant women except in the last four months of pregnancy. These restricting provisions were assumed to save one-third of such payments or \$16 million in fiscal year 1982.

Section 60C: Change Unemployed Parent to Primary Wage Earner.

Cost estimate : This proposal would limit eligibility for the AFDC Unemployed Parents program to two-parent families in which the principal earner is unemployed. Savings would be negligible.

Section 60D: Require AFDC Parent Attending College to Meet Work Requirements.

Cost estimate : This provision would require AFDC parents who are college students to seek full-time employment and meet all other AFDC work requirements. Savings would be negligible.

Section 60E: Require Retrospective Accounting and Monthly Reporting.

Cost estimate :

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority	0	-187	-195	-201	-207
Outlays	0	-187	-195	-201	-207

Basis of estimate : Savings may be possible in the AFDC program from the establishment of a mandatory nationwide monthly income reporting system and a one-month retrospective accounting system.

Currently, most AFDC programs base initial eligibility and benefit levels on estimates of the income the applicant expects to receive in the following month. Benefits then continue until the recipient reports a change in income, or until a change is determined in the course of casework.

This proposal would require the determination of each month's benefits on the basis of the previous month's income. The recipient would be required to mail a monthly income status form to the public assistance office before benefits were calculated and a check mailed. Information from a 1976-1977 pilot program suggests that such changes could result not only in budgetary savings, but also in simplified eligibility determinations, more rapid processing of initial applications, and increased responsiveness to changing needs of recipients.

The major savings would be generated through the monthly reporting requirement, which would reveal changes in income not reported or detected under the current system. Such a system would improve the efficiency of program operation through more accurate calculations of benefits for those with fluctuating incomes and by more rapid elimination of those cases that become ineligible. Because of offsetting startup costs, no net savings can be expected the first year.

Section 60G: Remove Limitation on the Number of Vendor Payments.

Cost estimate: This provision would remove the limit on the proportion of AFDC cases in which vendor payments can be made. There would be no budgetary impact.

Section 60H: Recover Overpayments/Pay Underpayments.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-115	-110	-106	-102	-98
Outlays.....	-115	-110	-106	-102	-98

Basis of estimate: This provision would require States to recoup AFDC overpayments and pay underpayments; current regulations give States the option of recouping overpayments and then only under certain circumstances. The Administration has estimated that this provision would save \$115 million in fiscal year 1982 and smaller amounts in ensuing years. CBO concurs with this estimate.

Section 60I: Reduce Federal Matching For Training.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-16	-17	-18	-20	-20
Outlays.....	-16	-17	-18	-20	-20

Basis of estimate: This provision would reduce the federal matching rate for training expenses from 75 to 50 percent. CBO concurs with the Administration's estimate.

Provision: Administrative Savings.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-105	-111	-117	-123	-128
Outlays.....	-105	-111	-117	-123	-128

Basis of estimate: The Administration has estimated that their AFDC reform proposals would result in a 12 percent savings in administrative expenses in fiscal year 1982. Their cost estimate, with which CBO originally concurred, is shown above.

Section 61: Enforce Collection of Child Support and Alimony.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-27	-30	-33	-36	-40
Outlays.....	-27	-30	-33	-36	-40

Basis of estimate: This proposal would require the IRS, at the request of a state, to deduct from the federal income tax refund due an absent parent the overdue amount of child support and alimony and to send that amount to the state. The Administration has estimated that this proposal would save \$27 million in fiscal year 1982 and CBO concurs with this estimate.

Section 62: Collection of Support for Adults.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-23	-23	-23	-23	-23
Outlays.....	-23	-23	-23	-23	-23

Basis of estimate: This provision would permit the enforcement of existing alimony obligations on behalf of AFDC families and use collections to reimburse AFDC costs in the same manner as child support collections. CBO concurs with the Administration's cost estimate which is shown above.

Section 63: Modify Collection Fee for Non-AFDC Cases.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-45	-49	-55	-59	-65
Outlays.....	-45	-49	-55	-59	-65

Basis of estimate: This provision would require states to collect a fee equal to 10 percent of the amount of child support owed from non-AFDC families. No part of the amount collected would be considered a fee except amounts which exceed the actual amount of the support owed. CBO estimates that this proposal would produce a new savings of \$45 million in fiscal year 1982 due to decreased federal matching payments for administrative expenses.

Section 64: Prohibit Discharge of Child Support in Bankruptcy Cases.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Budget authority.....	-17	-21	-26	-33	-41
Outlays.....	-17	-21	-26	-33	-41

Basis of estimate: Under this provision, a debt that is an AFDC child support obligation assigned to a state would not be released because of bankruptcy. CBO concurs with the Administration's estimate of savings shown above.

SUPPLEMENTAL SECURITY INCOME

Section 71: To change the basis for determining Supplemental Security Income benefit levels from a quarterly prospective accounting period to a one-month retrospective period, except in certain circumstances.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Required budget authority.....	-30	-60	-60	-60	-60
Estimated outlays.....	-30	-60	-60	-60	-60

Basis of estimate: An enactment date of July 15, 1981 was assumed for this provision, which would result in an effective date of January 1, 1982 according to the language of the provision. With the exception of fiscal year 1982, CBO's estimate is the same as that of the Administration. The same proposal in the Reagan budget shows a full-year's savings (\$60) in fiscal year 1982.

Section 72: To eliminate reimbursements to state vocational rehabilitation agencies for services to blind and disabled Supplemental Security Income (SSI) recipients.

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Reimbursement savings:					
Estimated authorization level.....	-20	-20	-20	-20	-20
Estimated outlays.....	-20	-20	-20	-20	-20
Offsetting benefit costs:					
Required budget authority.....	0	2	5	9	14
Estimated outlays.....	0	2	5	9	14
Net budgetary impact:					
Estimated authorization level.....	-20	-20	-20	20	-20
Required budget authority.....	0	2	5	9	14
Estimated outlays.....	-20	-18	-15	-11	-6

Basis of estimate: Direct benefits under the SSI program are an entitlement; reimbursements to the states for vocational rehabilitation services provided to SSI recipients, however, are funded at the discretion of the Appropriations Committees. The estimate above assumes that the fiscal year 1982 requested appropriation level for this activity would be funded in that year and through fiscal year 1986 in the absence of this provision.

According to a study prepared by the Division of Disability Studies of the Social Security Administration¹, the savings to the Disability Insurance (DI) Trust Fund over a five year period for DI recipients completing a program of vocational rehabilitation would represent approximately \$0.68 for every dollar spent on the program. These savings would result from the termination from DI rolls of rehabilitated individuals who obtained employment and became self-supporting. The above estimate of offsetting increases in SSI benefit costs assumes

¹ Leo A. McManus, "Evaluation of Disability Insurance Savings Due to Beneficiary Rehabilitation," Social Security Bulletin, Vol. 44 (February 1981), pp. 19-26.

that the SSI program is currently experiencing a similar reduction in benefit costs as a result of its vocational rehabilitation funding. If this funding is eliminated and the state agencies cease providing these services to SSI beneficiaries, the savings would no longer accrue.

An effective date of October 1, 1981 was assumed.

Estimate comparison: The Administration estimates the same level of savings to result from this proposal as CBO, but includes no offsetting increases in benefit costs.

SOCIAL SERVICES PROGRAMS

Section 82: Social Service Block Grant.

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Changes in estimated authorization level.....		-993	-1,166	-1,319		
Changes in estimated outlays.....		-993	-1,166	-1,319		

Basis of estimate: The existing portions of the Social Security Act relating to child welfare services, foster care, and adoption assistance would be repealed by this provision. In addition, the existing Title XX social services grant programs would be replaced by a social services block grant which would incorporate all the current Title XX programs as well as those programs which would be repealed. This proposal would establish a \$2.639 billion block grant ceiling each year. This ceiling is a 25 percent reduction from the fiscal year 1981 funding levels and a \$993 million reduction in 1982 from the 1982 baseline projection. The baseline reflected the authorized ceiling levels for Title XX and discretionary inflation in the other programs. The outyear savings grow to \$1.319 billion by 1984 since the block grant is level funded.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., June 9, 1981.

HON. ROBERT DOLE,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 202 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimates of the bill for reducing spending in programs within the jurisdiction of the Senate Committee on Finance. These estimates cover the provisions that affect Medicare and Medicaid. Estimates of provisions affecting primarily Social Security, SSI, Unemployment Insurance, Trade Adjustment Assistance and Social Services have already been forwarded under separate cover.

The estimates included in the attached report represent the 1981-1986 effects on the federal budget of the Committee's legislative proposals. CBO understands that the staff of the Committee on the Budget will be responsible for interpreting how the savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimates.

Sincerely,

JAMES BLUM,
(For Alice M. Rivlin, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

JUNE 9, 1981.

1. Bill title: Provisions Reducing Spending in Programs Within Jurisdiction of Senate Committee on Finance.

2. Bill status: As ordered sent to the Senate Budget Committee by the Senate Committee on Finance on May 5, 1981.

3. Bill purpose: To bring the expenditures authorized by the Senate Committee on Finance within the reconciliation target for that Committee established by the Congress.

4. Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Medicare:						
Revenues-----		109	408	798	1,108	1,358
Budget authority-----	-3	-419	-590	-532	-423	-338
Outlays-----	639	-2,011	-1,959	-2,074	-2,122	-2,192
Medicaid:						
Budget authority-----	-127	-1,392	-1,769	-2,359	-2,899	-3,399
Outlays-----	-127	-1,002	-1,629	-2,229	-2,779	-3,289
Other:						
Estimated authorization level-----		320	530	520	500	460
Outlays-----		320	530	520	500	460
Off-budget costs:						
Budget authority-----		90	150	140	140	130
Outlays-----		90	150	140	140	130

The savings resulting from this bill fall within budget function 550.

5. Basis of estimate: The estimates are based on description of the provisions in the Finance Committee's May 6, 1981 press release, early draft language, revised draft language dated May 28, 1981, and discussions with staff of the Committee. The basis of estimate statements are included under each section. This estimate covers provisions that affect Medicare and Medicaid. Estimates of provisions affecting primarily Social Security, SSI, Unemployment Insurance, Trade Adjustment Assistance and Social Services have been forwarded under separate cover. The section numbers were determined from a draft of the bill, and may not match those in the final version of the bill in all cases.

6. Estimate comparison: Where applicable, comparisons with other estimates are discussed by section.

7. Previous CBO estimate: Where applicable, previous CBO estimates are discussed by section under "Basis of Estimate."

8. Estimate prepared by: Malcolm Curtis and Hinda Ripps (225-7766).

9. Estimate approved by:

JAMES BLUM,
Assistant Director for Budget Analysis.

HEALTH PROGRAMS

Section 11: Routine Nursing Differential

Cost estimate (by fiscal years) :

Medicare :

Budget authority :

Millions

1981	-----	*
1982	-----	\$5
1983	-----	16
1984	-----	30
1985	-----	46
1986	-----	67

Outlays :

1981	-----	-20
1982	-----	-130
1983	-----	-150
1984	-----	-185
1985	-----	-230
1986	-----	-280

Basis of estimate: The provision would reduce the Medicare routine nursing salary cost differential from 8.5 percent to 4.5 percent. The estimates were obtained by apportioning Administration estimates of savings from eliminating the differential entirely.

Sec. 12: Occupational Therapy as Basis for Home Health Services

Cost estimate (by fiscal years) :

Medicare :

Budget authority :

Millions

1982	-----	\$1
1983	-----	4
1984	-----	8
1985	-----	12
1986	-----	16

Outlays :

1982	-----	-35
1983	-----	-41
1984	-----	-46
1985	-----	-52
1986	-----	-58

Basis of estimate: This section would repeal the provision of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) that makes occupational therapy a qualifying criterion for home health benefits. Administration estimates of savings have been reviewed by CBO.

Previous CBO estimate: Upon enactment of the Omnibus Reconciliation Act on December 5, 1980, CBO estimated the costs, shown below, of the provision that this bill would repeal.

Outlays :

Fiscal years :

Millions

1982	-----	\$15
1983	-----	33
1984	-----	65
1985	-----	124
1986	-----	150

The revised estimates follow discussions of underlying assumptions with actuaries in the Health Care Financing Administration.

Section 13: Alcohol Detoxification Facility Services

Cost estimate: This provision would have no significant impact on the federal budget.

Basis of estimate: This section would repeal the provision of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) that provides Medicare reimbursement for alcohol detoxification services in freestanding facilities. Upon enactment of the Omnibus Reconciliation Act on December 5, 1980, CBO estimated that that provision would have no significant impact on the budget. Repeal of the provision, therefore, would also be expected to have no significant budgetary impact. Because the cost of detoxification is three times greater in a hospital than a freestanding facility, CBO assumes that the costs of additional services reimbursed would be offset by savings from the substitution of care in freestanding facilities for care in hospitals.

Estimate comparison: The Administration estimates that repeal of this provision would reduce federal spending.

Outlays:

Fiscal years	Millions
1982	—\$70
1983	—90
1984	—110
1985	—120
1986	—130

The Administration assumes that, in the future, the cost per episode of detoxification would be the same in freestanding facilities and in hospitals. Consequently, the Administration's estimates include no offsetting savings from the substitution of care in freestanding facilities for care in hospitals.

Section 14: Inpatient Dental Coverage

Cost estimate (by fiscal years):

Medicare:

Budget authority:	Millions
1982	*
1983	\$1
1984	3
1985	4
1986	6
Outlays:	
1982	—12
1983	—13
1984	—16
1985	—18
1986	—20

Basis of estimate: This section would repeal the provision of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) that provides Medicare coverage for hospital stays warranted by the severity of a dental procedure or the medical condition of a dental patient. Administration estimates of savings have been reviewed by CBO.

Previous CBO estimate: Except for sign, these estimates are identical to CBO's estimates for the provision as enacted December 5, 1980.

Section 15: Open Enrollment

Cost estimate (by fiscal years) :

Medicare :

Budget authority :	Millions
1981	\$-1
1982	-9
1983	-10
1984	-11
1985	-13
1986	-15
Outlays :	
1981	-1
1982	-9
1983	-10
1984	-11
1985	-13
1986	-15

Basis of estimate: This section would repeal the provision of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) permitting enrollment of eligible individuals in the Supplementary Medical Insurance program at any time. The section would reestablish the January-through-March open enrollment period that applied before April 1981. Administration estimates of outlay savings have been reviewed by CBO.

Previous CBO estimate: Upon enactment of the Omnibus Reconciliation Act on December 5, 1980, CBO estimated that the provision that would be repealed by this section would have no significant effect on the budget. That estimate was incorrect. Generally, earlier enrollments and reenrollments, which would mean additional months of benefits, would be likely, given an unrestricted open enrollment period.

Section 16: Buy-in Agreements

Cost estimate:

(By fiscal years, in millions of dollars)

	1982	1983	1984	1985	1986
Medicare:					
Revenues	-1	-2	-2	-2	-2
Budget authority	-2	-2	-2	-2	-2
Outlays	-8	-9	-10	-12	-13
Medicaid: ¹					
Budget authority	-1	-1	-1	-1	-1
Outlays	-1	-1	-1	-1	-1

¹ Savings have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal medicaid savings would accrue from adoption of sec. 16.

This section would terminate the coverage under Supplementary Medical Insurance of persons covered pursuant to state buy-in agreements made or modified in 1981. No states have yet made or modified such agreements in 1981, but it is likely that Puerto Rico and seven states—Alaska, Connecticut, Michigan, Oklahoma, Oregon, Tennessee, and Wisconsin—would do so in the absence of this legislation. CBO's estimates are based on discussions with Administration officials and with the various states.

Section 17: Periodic Interim Payments

Cost estimate (by fiscal years):

Medicare:

Budget authority:

1981	-----	\$ -2
1982	-----	*
1983	-----	—
1984	-----	—
1985	-----	—
1986	-----	—

Outlays:

1981	-----	685
1982	-----	-692
1983	-----	—
1984	-----	—
1985	-----	—
1986	-----	—

Section 17 would repeal the one-time delay of three weeks in Medicare payments to hospitals under the periodic interim payment (PIP) procedure. The delay was adopted as part of the Omnibus Reconciliation Act of 1980 on December 5, 1980. The estimates above are based on current CBO estimates of Medicare payments to hospitals in the fourth quarter of fiscal year 1981, of which about 45 percent are expected to be made under the PIP system. The estimates assume that hospitals would find ways to increase payments before the delay sufficient to offset about 10 percent of the savings expected otherwise.

Previous CBO estimate: Except for sign, these estimates are identical to CBO's estimates for the provision of the Omnibus Reconciliation Act as enacted December 5, 1980.

Estimate comparison: The Administration's estimates of the budgetary impact of section 17 are shown below.

Outlays:

Fiscal years:

Millions

1981	-----	\$515
1982	-----	-522
1983	-----	—
1984	-----	—
1985	-----	—
1986	-----	—

The estimates differ from CBO's estimates almost entirely because the Administration assumes that hospitals would find ways to increase payments before the delay sufficient to offset one-third of the savings expected otherwise.

Section 18: Pneumococcal Pneumonia Vaccine

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....	-44	-24	-24	-4	-5
Outlays.....	-44	-24	-24	-4	-5
Medicaid:					
Budget authority.....	8	1	1	1	1
Outlays.....	8	1	1	1	1

Basis of estimate: This provision would rescind Medicare coverage of pneumococcal pneumonia vaccine. In place of Medicare coverage, vouchers good for \$10 towards purchase of the vaccine would be supplied once in fiscal year 1982 to noninstitutionalized elderly recipients of Supplementary Security Income (SSI) payments. Moreover, on a permanent basis through the Medicaid program, the federal government would pay up to \$10 per vaccination for persons 65 or older who are eligible for Medicaid or who are eligible for SSI benefits but did not receive a voucher.

Most of the Medicare savings arise from repeal of the Medicare vaccination benefit. Some savings also accrue each year from the reduced incidence of pneumonia in the vaccinated population. These savings are partially offset by additional medical costs for those whose lives would be prolonged. The Medicaid costs are the costs of the vaccinations. The estimates assume a 30 percent vaccination rate for the 2.2 million recipients of vouchers in fiscal year 1982. For the approximately 1.8 million elderly persons otherwise eligible for the vaccine, a vaccination rate of 10 percent is assumed in the first year and 5 percent in each subsequent year. The vaccine is expected to reduce by 9 percent the incidence of pneumonia among those vaccinated. The vaccine would extend the lives of the nearly 20 percent of elderly victims of pneumonia for whom the disease is fatal.

Section 19: Civil Money Penalties

Cost Estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....	-7	-7	-7	-7	-7
Outlays.....	-7	-7	-7	-7	-7
Medicaid:¹					
Budget authority.....	-14	-14	-14	-14	-14
Outlays.....	-14	-14	-14	-14	-14

¹ Savings have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal Medicaid savings would accrue from adoption of sec. 19.

Basis of estimate: This section would authorize the Secretary of Health and Human Services to fine any person who in his determination has filed a fraudulent claim for Medicare or Medicaid reimbursement. Administration estimates of outlay savings have been reviewed by CBO.

Section 20: Less Frequent SNF Surveys

Cost estimate (by fiscal years):

Medicare:		<i>Millions</i>
Budget authority:		
1982	-----	-----
1983	-----	-----
1984	-----	\$1
1985	-----	1
1986	-----	1
Outlays:		
1982	-----	-4
1983	-----	-4
1984	-----	-4
1985	-----	-4
1986	-----	-4

Basis of estimate: This section would eliminate the existing 12-month limitation on the duration of participation agreements with skilled nursing facilities (SNFs). Annual certification surveys would no longer be required. CBO has reviewed Administration estimates of savings.

Section 20A: Closure and Conversion of Underutilized Facilities

Cost estimate:

(By fiscal years, in millions of dollars)

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....			1	4	7
Outlays.....	-2	-7	-19	-36	-58
Medicaid: ¹					
Budget authority.....		-2	-4	-8	-14
Outlays.....		-2	-4	-8	-14

¹ Savings have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal Medicaid savings would accrue from adoption of sec. 20A.

Basis of estimate: Section 20A would authorize payments under Medicare and Medicaid to nonprofit short-stay hospitals for additional capital and operating costs associated with the closing-down or conversion to approved use of underutilized bed capacity or services. Such payments could include amounts for repayment of the outstanding debt of a hospital completely closed down. The effects of this provision on federal spending are unpredictable because they would depend critically on the actions of the Hospital Transitional Allowance Board, which would review applications for payments under the provision. The savings shown above, therefore, are highly speculative.

Previous CBO estimate: These estimates are similar to those CBO provided to the Senate Committee on Finance on September 9, 1980 for a nearly identical provision of S. 2885, the Reconciliation Act of 1980, as approved by the Senate on June 30, 1980.

Section 20B: Reasonable Charges for Physicians' Services

Cost estimate (by fiscal years):

Medicare:

Budget authority:	Millions
1982.....	\$-13
1983.....	-21
1984.....	-25
1985.....	-25
1986.....	-26
Outlays:	
1982.....	-13
1983.....	-21
1984.....	-25
1985.....	-25
1986.....	-26

Basis of estimate: This provision would prohibit any increase in the local prevailing charge for a physician's service to the extent that such charges would be more than one-third greater than the median fee for that service in the state. The provision would also permit new physicians setting up practices in localities with lower fee levels to establish their customary charges at the 75th percentile of prevailing

charges, instead of the 50th. In addition, the provision would allow doctors presently practicing in designated physician-shortage areas to move up to the 75th percentile. Administration estimates of outlay savings have been adjusted by CBO for a later assumed effective date.

Previous CBO estimate: Except that the assumed effective date is one year later, these estimates are identical to those CBO provided to the Senate Committee on Finance on September 9, 1980 for an identical provision of S. 2885, the Reconciliation Act of 1980, as passed by the Senate on June 30, 1980.

Section 20C: Limits on Costs and Charges for Outpatient Services

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....	1	2	4	6	9
Outlays.....	-15	-23	-27	-31	-36
Medicaid: ¹					
Budget authority.....	-2	-3	-4	-5	-5
Outlays.....	-2	-3	-4	-5	-5

¹ Costs have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal medicaid savings would accrue from adoption of sec. 20C.

Basis of estimate: This section would require the Secretary of Health and Human Services to establish limits on the costs or charges that would be considered reasonable for purposes of Medicare reimbursement for outpatient services. Because the effect of the provision depends entirely on regulations to be issued by the Secretary, the savings shown above are highly speculative.

Previous CBO estimate: These estimates are similar to those CBO provided to the Senate Committee on Finance on September 9, 1980 for a nearly identical provision of S. 2885, the Reconciliation Act of 1980, as passed by the Senate on June 30, 1980.

Section 20D: Inappropriate Hospital Services Exclusion

Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985	1986
Medicare:						
Budget authority.....		4	11	20	30	41
Outlays.....	-25	-90	-100	-115	-130	-150
Medicaid: ¹						
Budget authority.....	-5	-25	-30	-35	-40	-45
Outlays.....	-5	-25	-30	-35	-40	-45

¹ Savings have been estimated relative to current law. If sec. 21 of this bill is adopted, after 1981 not all of these additional Federal medicaid savings would accrue from adoption of sec. 20D.

Basis of estimate: This section would modify a provision of current law enacted as part of the Omnibus Reconciliation Act of 1980 on December 5, 1980. That provision reduces Medicare and Medicaid payments for care for persons hospitalized only because needed long-term care beds are unavailable. The provision exempts hospitals with occupancy rates of at least 80 percent, however, reducing gross savings an estimated 45 percent. Section 20D would repeal the exemption.

Section 20E: Increase Part B Deductible

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....	-120	-210	-240	-250	-260
Outlays.....	-120	-210	-240	-250	-260
Medicaid: ¹					
Budget authority.....	9	16	19	20	20
Outlays.....	9	16	19	20	20

¹ Costs have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal Medicaid costs would accrue from adoption of sec. 20E.

Basis of estimate: Section 20E would increase from \$60 to \$75 the annual deductible for Medicare Supplementary Medical Insurance. Administration estimates of Medicare savings have been reviewed by CBO. There would be additional Medicaid costs, however, on behalf of individuals enrolled in both Medicaid and Medicare. CBO has calculated these costs assuming that 14 percent of Medicare enrollees are also enrolled in Medicaid.

Section 20F: Deletion of Part B Carryover

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority.....	-55	-55	-55	-55	-55
Outlays.....	-55	-55	-55	-55	-55
Medicaid: ¹					
Budget authority.....	4	4	4	4	4
Outlays.....	4	4	4	4	4

¹ Costs have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal Medicaid costs would accrue from adoption of sec. 20F.

Basis of estimate: This section would require that the Supplementary Medical Insurance deductible be satisfied on an annual basis. Under existing law, expenses incurred in the last quarter of the preceding calendar year may be applied to the deductible for the current year. CBO has reviewed Administration estimates of Medicare savings. Offsetting Medicaid costs for joint Medicare and Medicaid enrollees have been estimated by CBO assuming 14 percent joint enrollment.

Section 20G: Part B Premiums

Cost estimate:

[By fiscal years, in million of dollars]

	1982	1983	1984	1985	1986
Medicare: Revenues.....	110	410	800	1,110	1,360
Medicaid: ¹					
Budget authority.....	10	30	65	85	105
Outlays.....	10	30	65	85	105

¹ Costs have been estimated relative to current law. If sec. 21 of this bill is adopted, not all of these additional Federal Medicaid costs would accrue from adoption of sec. 20G.

Basis of estimate: Section 20G would set the premium for Supplementary Medical Insurance at 25 percent of total program cost per enrollee plus a contingency allowance. Under current law, the premium is equal to half of program costs per aged enrollee except that the premium cannot increase by more than the increase in the basic Social Security benefit in the preceding July. Because of the limit on the annual percentage increase, premiums have fallen rapidly as a fraction of program cost. Section 20G would remove the limit and permanently set premiums at approximately the present percentage of total program costs. The revenue increases shown are the differences between estimated premium collections under current law and such receipts under the bill. It has been assumed that the higher premiums would have no significant impact on SMI enrollment, which is voluntary.

Section 20H: Medicare Secondary for End-Stage Renal Disease

Cost estimate (by fiscal years):

Medicare:

Budget authority:	Millions
1982	\$-95
1983	-165
1984	-180
1985	-195
1986	-215
Outlays:	
1982	-95
1983	-165
1984	-180
1985	-195
1986	-215

Basis of estimate: Section 20H would make Medicare the secondary payer during the first year of renal dialysis; Medicare would pay only its share of costs not covered by a private insurance plan. Under present law, Medicare is the primary payer beginning three months after dialysis commences. The provision would apply only to individuals under 65 not entitled to Medicare benefits by reason of receipt of disability payments.

Under the provision, CBO estimates that about 90 percent of current annual Medicare costs per affected enrollee (about \$21,000 for 9,400 enrollees) would be shifted to private insurers for the last three quarters of the first year of dialysis. Savings in the first year have been reduced because enrollments occur throughout the year. These estimates assume that the provision is drafted in such a way that private insurers would not be able to exclude coverage of end-stage renal disease from their policies.

Section 201: Medicare Secondary to Federal Employees Plans

Cost estimate:

[By fiscal years, in millions of dollars]

	1982	1983	1984	1985	1986
Medicare:					
Budget authority	-85	-130	-55	25	100
Outlays	-680	-1,120	-1,110	-1,060	-990
Other agency costs:					
Estimated authorization level	320	530	520	500	460
Outlays	320	530	520	500	460
Offbudget costs:					
Budget authority	90	150	140	140	130
Outlays	90	150	140	140	130

Basis of estimate: This section would make Medicare the secondary payer on claims for enrollees also entitled to benefits under one of the Federal Employees Health Benefits (FEHB) plans. The provision would therefore shift costs from Medicare to the FEHB plans. Only about 60 percent of the additional FEHB costs would be borne by the federal government, however, and some of those federal costs—those for postal workers—would appear off budget. Administration estimates of outlay savings have been reviewed by CBO.

Sections 21–29: Medicaid Provisions

Cost estimate (by fiscal years):

Budget authority:	Millions
1981	—\$122
1982	—1,400
1983	—1,770
1984	—2,360
1985	—2,900
1986	—3,400
Outlays:	
1981	—122
1982	—1,010
1983	—1,630
1984	—2,230
1985	—2,780
1986	—3,290

Basis of estimate: The amendments to Title XIX of the Social Security Act would impose limits on federal Medicaid expenditures while allowing the states more flexibility with which to run their programs. Section 21 would cap federal Medicaid expenditures. Section 22 would decrease the minimum federal medical assistance percentage from 50 percent to 40 percent. These two sections form the basis for the estimated savings in this proposal.

Under Section 21, for each of the states plus the District of Columbia, expenditures in 1982 would be federally matched up to 109 percent of the state's estimated federal expenditures in 1981. These 1981 estimates are based on February estimates calculated by the states. In fact, some of the states have projected less than a 9 percent increase and are not expected to be affected by the cap. Beginning in 1983, federal expenditures for Medicaid in each of the states and the District of Columbia would be allowed to increase by the percentage equal to the Gross National Product Implicit Price Deflator. The deflators for 1983 through 1986 are 7.3 percent, 6.2 percent, 5.5 percent, and 5.0 percent, respectively. The allotment for the territories would be \$47 million for fiscal year 1982 and each year thereafter.

Section 22 would drop the minimum federal medical assistance percentage from 50 percent to 40 percent, thus affecting 12 states plus the District of Columbia.

Each state's federal Medicaid allotment for 1982 was determined by taking the lesser of the effect of a 9 percent cap, the effect of a reduction of the minimum match, or the state's estimate of federal expenditures in 1982 adjusted to CBO's current law projections. Savings were calculated from current law.

In addition to the cap and minimum match reduction, Section 23 would provide for the recovery of disputed claims to the federal gov-

ernment. Savings of \$122 million are expected in 1981 from recovery of outstanding disputed claims. Sections 24-29 would allow states more flexibility with which to operate their programs, including provisions such as cost sharing for services, limitation on freedom of choice, and competitive bidding. States might be able to utilize these provisions to meet the cap and the reduced minimum match. However, it is not possible to estimate what effect these provisions might have beyond the cap and minimum match on an individual state basis.

Estimate comparison: The Administration has estimated an outlay savings of \$1,069 million in 1982 from these proposals. The Administration's estimate is based upon state estimates calculated prior to January 1981, while CBO has utilized the February state estimates. CBO's savings estimates from this provision are lower than those of the Administration mostly because CBO's estimates of total current law Medicaid outlays are lower than those of the Administration.

V. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, the changes in existing law made by the bill as reported are shown below (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman) :

SOCIAL SECURITY ACT, AS AMENDED

TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

Appropriation

Section 1. For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, and (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services, [and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-care,] there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary"), State plans for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged.

* * * * *

Payment to States

Sec. 3. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

* * * * * *

[(4) in the case of any State whose State plan approved under section 2 meets the requirements of subsection (c) (1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c) (1) and are provided (in accordance with the next sentence) to applicants for or recipients of assistance under the plan to help them attain or retain capability for self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c) (1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of assistance under the plan, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such assistance; plus

[(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the politi-

cal subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act, are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) under conditions which shall be prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (i) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraph (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and]

(4) *in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—*

(A) *75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus*

(B) *one-half of the remainder of such expenditures.*

[(5) in the case of any State whose State plan approved under section 2 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the

proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.】

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which the Secretary of Health, Education, and Welfare finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

【(c) (1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 2 must provide that the State agency shall make available to applicants for recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision,
the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.]

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * *

Old-Age and Survivors Insurance Benefit Payments

Sec. 202. (a) ***

Child's Insurance Benefits

(d) (1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and

(i) either had not attained the age of 18 or was a full-time elementary or secondary school student and had not attained the age of [22] 19, or (ii) is under a disability (as defined in section 223(d)) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death,
or

(iii) is such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding which ever of the following first occurs—

(D) the month in which such child dies, or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time *elementary or secondary school* student during any part of such month.

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time *elementary or secondary school* student, or

(ii) the month in which he attains the age of [22] 19, but only if he was not under a disability (as so defined) in such earlier month; or

(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22, or, subject to section 223(e), the termination month (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c) (4) (A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity, or (if later) the earlier of—

(III) the first month during no part of which he is a full-time *elementary or secondary school* student, or

(IV) the month in which he attains the age of [22] 19, but only if he was not under a disability (as so defined) in such earlier month.

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each

month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1)(C) unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) or section 216(h)(3) shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1)(C) if, at such time, the child was living with or was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (e), (f), (g), or (h) of this section or under section 223(a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under section 223(a) or this subsection, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or this subsection unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entitled to benefits under section 223(a), he is entitled, for the month following such last month, to benefits under subsection (a) of this section.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he—

[(A) (i) is a full-time student or is under a disability (as defined in section 223(d)), and (ii) had not attained the age of 22, or (A) (i) is a full-time elementary or secondary school student and has not attained the age of 19 or (ii) is under a disability (as defined in section 223(d)) and has not attained the age of 22, or

(B) is under a disability (as so defined) which began before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability,

but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1) (D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time *elementary or secondary school* student, or (ii) the month in which he attains the age of [22] 19, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

(i) the first month during no part of which he is a full-time *elementary or secondary school* student, or

(ii) the month in which he attains the age of [22] 19.

(7) For the purposes of this subsection—

(A) A “full-time *elementary or secondary school* student is an individual who is in full-time attendance as a student at an [educational institution] *elementary or secondary school*, as determined by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the [institutions] *schools* involved, except that no individual shall be considered a “full-time *elementary or secondary school* student” if he is paid by his employer while attending an [educational institution] *elementary or secondary school* at the request, or pursuant to a requirement, of his employer. An individual shall not be considered a “full-time *elementary or secondary school* student” for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correction facility, pursuant to his conviction of an offense (committed after the date of the enactment of this paragraph) which constituted a felony under applicable law.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time *elementary or secondary school* student during any period of nonattendance at an [educational institution] *elementary or secondary school* at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an [educational institution] *elementary or secondary school* immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an [educational institution] *elementary or secondary school* immediately following such period.

[(C) An “educational institution” is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a non-

accredited school or college or university whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited.】

(C) (i) *An “elementary or secondary school” is a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located.*

(ii) *For the purpose of determining whether a child is a “full-time elementary or secondary school student” or “intends to continue to be in full-time attendance at an elementary or secondary school”, within the meaning of this subsection, there shall be disregarded any education provided, or to be provided, beyond grade 12.*

(D) A child who attains age [22] 19 at a time when he is a full-time elementary or secondary school student (as defined in subparagraph (A) of this paragraph and without the application of subparagraph (B) of such paragraph) but has not (at such time) completed the requirements for, or received a [degree from a four-year college or university] diploma or equivalent certificate from a secondary school (as defined in subparagraph (C) (i)) shall be deemed (for purposes of determining whether his entitlement to benefits under this subsection has terminated under paragraph (1) (F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1) (B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time (or, if the [educational institution] elementary or secondary school (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).

(8) In the case of—

(A) An individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or

(B) an individual entitled to disability insurance benefits, or an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits, a child of such individual adopted after such individual became entitled to such old-age or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1) (C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D) (i) was legally adopted by such individual in an adoption decreed by a court of competent jurisdiction within the United States,

(ii) was living with such individual in the United States and receiving at least one-half of his support from such individual

(I) if he is an individual referred to in subparagraph (A), for the year immediately before the month in which such individual became entitled to old-age insurance benefits or, if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, the month in which such period of disability began, or (II) if he is an individual referred to in subparagraph (B), for the year immediately before the month in which began the period of disability of such individual which still exists at the time of adoption (or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65), or the month in which such individual became entitled to disability insurance benefit, or (III) if he is an individual referred to in either subparagraph (A) or subparagraph (B) and the child is the grandchild of such individual or his or her spouse, for the year immediately before the month in which such child files his or her application for child's insurance benefits, and

(iii) had not attained the age of 18 before he began living with such individual.

In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of birth of such child.

(9)(A) A child who is a child of an individual under clause (3) of the first sentence of section 216(e) and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1)(C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.

(B) In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.

* * * * *

Lump-Sum Death Payments

(i) Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount (*as determined without regard to the amendments made by section 2 of the Omnibus Reconciliation Act of 1981 relating to the elimination of the minimum benefit*), or an amount equal to \$255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined by the Secretary to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

[(1) if all or part of the burial expenses of such insured individual which are incurred by or through a funeral home or funeral homes remains unpaid, to such funeral home or funeral homes to the extent of such unpaid expenses, but only if (A) any person who assumed the responsibility for the payment of all or any part of such burial expenses files an application, prior to the expiration of two years after the date of death of such insured individual, requesting that such payment be made to such funeral home or funeral homes, or (B) at least 90 days have elapsed after the date of death of such insured individual and prior to the expiration of such 90 days no person has assumed responsibility for the payment of any such burial expenses;

[(2) if all of the burial expenses of such insured individual which were incurred by or through a funeral home or funeral homes have been paid (including payments made under clause (1)), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such burial expenses;

[(3) if the body of such insured individual is not available for burial but expenses were incurred with respect to such individual in connection with a memorial service, a memorial marker, a site for the marker, or any other item of a kind for which expenses are customarily incurred in connection with a death and such expenses have been paid, to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such expenses; or

[(4) if any part of the amount payable under this subsection remains after payments have been made pursuant to clauses (1), (2), and (3), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid other expenses in connection with the burial of such insured individual, in the following order of priority: (A) expenses of opening and closing the grave of such insured individual, (B) expenses of providing the burial plot of such insured individual, and (C) any remaining expenses in connection with the burial of such insured individual.]

(1) to a widow (as defined in section 216(c)) or widower (as defined in section 216(g)) who is entitled (or would have been so entitled had a timely application been filed), on the basis

of the wages and self-employment income of such insured individual, to benefits under subsection (e), (f), or (g) of this section for the month in which occurred such individual's death; or

(2) if no person qualifies for payment under the provisions of paragraph (1), or if such person dies before receiving payment, in equal shares to each person who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (d) of this section for the month in which occurred such individual's death.

No payment [(except a payment authorized pursuant to clause (1) (A) of the preceding sentence)] shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(1)(1) are applicable, and who is returned to any State or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

* * * * *

[Minimum Survivor's Benefit

[(m) (1) In any case in which an individual is entitled to a monthly benefit under this section on the basis of a primary insurance amount computed under section 215 (a) or (d), as in effect after December 1978, on the basis of the wages and self-employment income of a deceased individual for any month and no other person is (without the application of subsection (j)(1)) entitled to a monthly benefit

under this section for that month on the basis of such wages and self-employment income, the individual's benefit amount for that month, prior to reduction under subsection (k) (3), shall not be less than that provided by subparagraph (C) (i) (I) of section 215(a) (1) and increased under section 215(i) for months after May of the year in which the insured individual died as though such benefit were a primary insurance amount.

[(2) In the case of any such individual who is entitled to a monthly benefit under subsection (e) or (f), such individual's benefit amount, after reduction under subsection (q) (1), shall be not less than—

[(A) \$84.50, if his first month of entitlement to such benefit is the month in which such individual attained age 62 or a subsequent month, or

[(B) \$84.50 reduced under subsection (q) (1) as if retirement age as specified in subsection (q) (6) (A) (ii) were age 62 instead of the age specified in subsection (q) (9), if his first month of entitlement to such benefit is before the month in which he attained age 62.

-(3) In the case of any individual whose benefit amount was computed (or recomputed) under the provisions of paragraph (2) and such individual was entitled to benefits under subsection (e) or (f) for a month prior to any month after 1972 for which a general benefit increase under this title (as defined in section 215(i) (3)) or a benefit increase under section 215(i) becomes effective, the benefit amount of such individual as computed under paragraph (2) without regard to the reduction specified in subparagraph (B) thereof shall be increased by the percentage increase applicable for such benefit increase, prior to the application of subsection (q) (1) pursuant to paragraph (2) (B) and subsection (q) (4).]

* * * * *

Reduction of Benefit Amounts for Certain Beneficiaries

(q) (1) If the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) $\frac{5}{9}$ of 1 percent of such amount if such benefit is an old-age insurance benefit, $\frac{25}{36}$ of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or $\frac{19}{40}$ of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by—

(B) (i) the number of months in the reduction period for such benefit (determined under paragraph (6) (A)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) if less, the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age;

and in the case of a widow or widower whose first month of entitlement to a widow's or widower's insurance benefit is a month before the month in which such widow or widower attains age 60, such benefit, reduced pursuant to the preceding provisions of this paragraph (and before the application of the second sentence of paragraph (8)), shall be further reduced by—

(C) $4\frac{3}{40}$ of 1 percent of the amount of such benefit, multiplied by—

(D) (i) the number of months in the additional reduction period for such benefit (determined under paragraph (6) (B)), if such benefit is for a month before the month in which such individual attains age 62, or

(ii) if less, the number of months in the additional adjusted reduced period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains age 62 or any month thereafter.

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such months had such individual attained age 65 in the first month for which he most recently became entitled to a disability insurance benefit.

(3) (A) If the first month for which an individual both is entitled to a wife's husband's, widows, or a widower's insurance benefit and has attained age 62 (in the case of a wife's or husband's insurance benefit) or age 50 (in the case of a widow's or widower's insurance benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains age 65), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such wife's, husband's widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance benefit and is not entitled to a disability insurance benefit, such individual's wife's, or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph (1) for such month, and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's or husband's insurance benefit (before reduction under this subsection) over such old-age insurance benefit (before reduction under this subsection).

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefits is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, widow's, or widower's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, widow's, or widower's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).

(E) If the first month for which an individual is entitled to an old-age insurance benefit (whether such first month occurs before, with, or after the month in which such individual attains the age of 65) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit to which such individual was first entitled for a month before she or he attained retirement age, then such old-age insurance benefit shall be reduced by whichever of the following is the larger:

(i) the amount by which (but for this subparagraph) such old-age insurance benefit would have been reduced under paragraph (1), or

(ii) the amount equal to the sum of (I) the amount by which such widow's or widower's insurance benefit would be reduced under paragraph (1) if the period specified in paragraph (6) (A) ended with the month before the month in which she or he attained age 62 and (II) the amount by which such old-age insurance benefit would be reduced under paragraph (1) if it were equal to the excess of such old-age insurance benefit (before reduction under this subsection over such widow's or widower's insurance benefit (before reduction under this subsection)).

(F) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs with or after the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit to which such individual was first entitled for a month before she or he attained retirement age, then such disability insurance benefit for each month shall be reduced by whichever of the following is larger:

(i) the amount by which (but for this subparagraph) such disability insurance benefit would have been reduced under paragraph (2), or

(ii) the amount equal to the sum of (I) the amount by which such widow's or widower's insurance benefit would be reduced under paragraph (1) if the period specified in paragraph (6) (A) ended with the month before the month in which she or he attained age 62 and (II) the amount by which such disability insurance benefit would be reduced under paragraph (2) if it were

equal to the excess of such disability insurance benefit (before reduction under this subsection) over such widow's or widower's insurance benefit (before reduction under this subsection).

(G) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs before the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e) (1) in the case of a widow or surviving divorced wife or subsection (f) (1) in the case of a widower, be) entitled to a widow's or widower's insurance benefit, then such disability insurance benefit for each month shall be reduced by the amount such widow's insurance benefit would be reduced under paragraphs (1) and (4) for such month as if the period specified in paragraph (6) (A) (or, if such paragraph does not apply, the period specified in paragraph (6) (B)) ended with the month before the first month for which she or he most recently became entitled to a disability insurance benefit.

(H) Notwithstanding subparagraph (A) of this paragraph, if the first month for which an individual is entitled to a widow's or widower's insurance benefit is a month for which such individual is also entitled to an old-age insurance benefit to which such individual was first entitled for that month or for a month before she or he became entitled to a widow's or widower's benefit, the reduction in such widow's or widower's insurance benefit shall be determined under paragraph (1).

(4) If—

(A) an individual is or was entitled to a benefit subject to reduction under paragraph (1) or (3) of this subsection, and

(B) such benefit is **[increased]** *changed* by reason of an **[increase]** *change* in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based, then the amount of the reduction of such benefit (after the application of any adjustment under paragraph (7)) for each month beginning with the month of such **[increase]** *change* in the primary insurance amount shall be computed under paragraph (1) or (3), whichever applies, as though the **[increased]** *changed* primary insurance amount had been in effect for and after the month for which the individual first became entitled to such monthly benefit reduced under such paragraph (1) or (3).

(5) (A) No wife's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by her with the Secretary, in accordance with regulations prescribed by him, in which she elects to receive wife's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which she has in her care (individually or jointly with the person on whose wages and self-employment income her wife's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A) (i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 203 (c) (2)) —

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the woman filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62, nor shall it be effective for any month to which subparagraph (A) (ii) applies.

(C) If a woman does not have in her care a child described in subparagraph (A) (ii) in the first month for which she is entitled to a wife's insurance benefit, and if such first month is a month before the month in which she attains age 65, she shall be deemed to have filed in such first month the certificate described in subparagraph (A) (i).

(D) No widow's insurance benefit for a month in which she has in her care a child of her deceased husband (or deceased former husband) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which she would have been entitled had she been entitled for such month to mother's insurance benefits on the basis of her deceased husband's (or deceased former husband's) wages and self-employment income.

(6) For the purposes of this subsection—

(A) the "reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the period—

(i) beginning—

(I) in the case of an old-age or husband's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit, or

(II) in the case of a wife's insurance benefit, with the first day of the first month for which a certificate described in paragraph (5) (A) (i) is effective, or

(III) in the case of a widow's or widower's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit or the first day of the month in which such individual attains age 60, whichever is the later, and

(ii) ending with the last day of the month before the month in which such individual attains retirement age; and

(B) the "additional reduction period" for an individual's widow's, or widower's insurance benefit is the period—

(i) beginning with the first day of the first month for which such individual is entitled to such benefit, but only if such individual has not attained age 60 in such first month, and

(ii) ending with the last day of the month before the month in which such individual attains age 60.

(7) For purposes of this subsection the "adjusted reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period prescribed in paragraph (6) (A) for such benefit, and the "additional adjusted reduction period" for an individual's, widow's, or widower's, insurance benefit is the additional reduction period prescribed by paragraph (6) (B) for such benefit, excluding from each such period—

(A) any month in which such benefit was subject to deductions under section 203(b), 203(c) (1), 203(d) (1), or 222(b),

(B) in the case of wife's insurance benefits, any month in which she had in her care (individually or jointly with the person on whose wages and self-employment income such benefit is based) a child of such person entitled to child's insurance benefits,

(C) in the case of wife's or husband's insurance benefits, any month for which such individual was not entitled to such benefits because of the occurrence of an event that terminated her or his entitlement to such benefits,

(D) in the case of widow's insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5) (D),

(E) in the case of widow's or widower's insurance benefits, any month before the month in which she or he attained age 62, and also for any later month before the month in which he attained retirement age, for which she or he was not entitled to such benefit because of the occurrence of an event that terminated her or his entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

[(8) This subsection shall be applied after reduction under section 203(a) and after application of section 215(g). If the amount of any reduction computed under paragraph (1), (2), or (3) is not a multiple of \$0.10, it shall be reduced to the next lower multiple of \$0.10]

(8) This subsection shall be applied after reduction under section 203(a) and before application of section 215(g):

(9) For purposes of this subsection, the term "retirement age" means age 65.

(10) For purposes of applying paragraph (4), with respect to monthly benefits payable for any month after December 1977 to an individual who was entitled to a monthly benefit as reduced under paragraph (1) or (3) prior to January 1978, the amount of reduction in such benefit for the first month for which such benefit is [increased] *changed* by reason of an [increase] *change* in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based and for all subsequent months (and similarly for all subsequent [increases] *changes*) shall be [increased] *changed* by a percentage equal to the percentage [increase] *change* in such primary insurance amount (such [increase] *change* being made in accordance with the provisions of paragraph (8)). In the case of an individual whose reduced benefit under this section is [increased] *changed* as a result of the use of an adjusted reduction period or an additional adjusted reduction period (in accordance with paragraphs (1) and (3) of this subsection), then for the first month for which such [increase] *change* is effective, and for all subsequent months, the amount of such reduction (after the application of the previous sentence, if applicable) shall be determined—

(A) in the case of old-age, wife's, and husband's insurance benefits, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period to (ii) the number of months in the reduction period,

(B) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 62, by multi-

plying such amount by the ratio of (i) the number of months in the reduction period beginning with age 62 multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $\frac{43}{240}$ of 1 percent to (ii) the number of months in the reduction period multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the additional reduction period multiplied by $\frac{43}{240}$ of 1 percent, and

(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 65, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $\frac{43}{240}$ of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by $\frac{19}{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $\frac{43}{240}$ of 1 percent.

such determination being made in accordance with the provisions of paragraph (8).

(11) When an individual is entitled to more than one monthly benefit under this title and one or more of such benefits are reduced under this subsection, paragraph (10) shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (3).

* * * * *

Increase in Old-Age Insurance Benefit Amounts on Account of Delayed Retirement

(w)(1) The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3) as in effect in December 1978 or section 215(a)(1)(C) (i) **[(II)]** as in effect thereafter) which is payable without regard to this subsection to an individual shall be increased by—

(A) one-twelfth of 1 percent of such amount, or, in the case of an individual who first becomes eligible for an old-age insurance benefit after December 1978, one-quarter of 1 percent of such amount multiplied by

(B) the number (if any) of the increment months for such individual.

(2) For purposes of this subsection, the number of increment months for any individual shall be a number equal to the total number of the months—

(A) which have elapsed after the month before the month in which such individual attained age 65 or (if later) December 1970 and prior to the month in which such individual attained age 72, and

(B) with respect to which—

(i) such individual was a fully insured individual (as defined in section 214(a)), and

(ii) such individual either was not entitled to an old-age insurance benefit or suffered deductions under section 203(b) or 203(c) in amounts equal to the amount of such benefit.

(3) For purposes of applying the provisions of paragraph (1), a determination shall be made under paragraph (2) for each year, beginning with 1972, of the total number of an individual's increment months through the year for which the determination is made and the total so determined shall be applicable to such individual's old-age insurance benefits beginning with benefits for January of the year following the year for which such determination is made; except that the total number applicable in the case of an individual who attains age 72 after 1972 shall be determined through the month before the month in which he attains such age and shall be applicable to his old-age insurance benefit beginning with the month in which he attains such age.

(4) This subsection shall be applied after reduction under section 203(a).

(5) If an individual's primary insurance amount is determined under paragraph (3) of section 215(a) as in effect in December 1978, or section 215(a) (1) (C) (i) **[(II)]** as in effect thereafter, and, as a result of this subsection, he would be entitled to a higher old-age insurance benefit if his primary insurance amount were determined under section 215(a) (whether before, in, or after December 1978) without regard to such paragraph, such individual's old-age insurance benefit based upon his primary insurance amount determined under such paragraph shall be increased by an amount equal to the difference between such benefit and the benefit to which he would be entitled if his primary insurance amount were determined under such section without regard to such paragraph.

Reduction of Insurance Benefits

Maximum Benefits

Sec. 203. (a) (1) In the case of an individual whose primary insurance amount has been computed or recomputed under section 215(a) (1) or (4), or section 215(d), as in effect after December 1978, the total monthly benefits to which beneficiaries may be entitled under section 202 or 223 for a month on the basis of the wages and self-employment income of such individual shall, except as provided by paragraphs (3) and (6) (but prior to any increases resulting from the application of paragraph (2) (A) (ii) (III) of section 215(i)), be reduced as necessary so as not to exceed—

(A) 150 percent of such individual's primary insurance amount to the extent that it does not exceed the amount established with respect to this subparagraph by paragraph (2),

(B) 272 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (A) but does not exceed the amount established with respect to this subparagraph by paragraph (2),

(C) 134 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (B) but does not exceed the amount established with respect to this subparagraph by paragraph (2), and

(D) 175 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (C).

[Any such amount that is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10.]

(2) (A) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in the calendar year 1979, the amounts established with respect to subparagraphs (A), (B), and (C) of paragraph (1) shall be \$230, \$332, and \$433, respectively.

(B) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established for the calendar year 1979 by subparagraph (A) of this paragraph and the quotient obtained under paragraph (B)(ii) of section 215(a)(1), with such product being rounded in the manner prescribed by section 215(a)(1)(B)(iii).

(C) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula which (except as provided in section 215(i)(2)(D)) is to be applicable under this paragraph to individuals who become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the following calendar year.

(D) A year shall not be counted as the year of an individual's death or eligibility for purposes of this paragraph or paragraph (8) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefits to which he was entitled during such 12 months).

(3) (A) When an individual who is entitled to benefits on the basis of the wages and self-employment income of any insured individual and to whom this subsection applies would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits for a month on the basis of the wages and self-employment income of one or more other insured individuals, the total monthly benefits to which all beneficiaries are entitled on the basis of such wages and self-employment income shall not be reduced under this subsection to less than the smaller of—

(i) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or

(ii) an amount equal to the product of 1.75 and the primary insurance amount that would be computed under section 215(a)(1) for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 230.

(B) When two or more persons were entitled (without the application of section 202(j) (1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

(i) the amount determined under this subsection without regard to this subparagraph,

(ii) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

(iii) if any persons are entitled to benefits on the basis of such wages and self-employed income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 215(i) (3)) or a benefit increase under the provisions of section 215(i), an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this title (excluding any part thereof determined under section 202(w)) for the month before such effective month (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase provided under such benefit increase [(with any such increased amount which is not a multiple of \$0.10 being rounded to the next higher multiple of \$0.10)];

but in any such case (I) subparagraph (A) of this paragraph shall not be applied to such total of benefits after the application of clause (ii) or (iii), and (II) if section 202(k) (2) (A) was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of clause (ii) or (iii) shall be applied, for and after the month in which section 202(k) (2) (A) ceases to apply, as though subparagraph (A) of this paragraph had not been applicable to such total of benefits for the last month for which clause (ii) or (iii) was applicable.

(C) When any of such individuals is entitled to monthly benefits as a divorced spouse under section 202 (b) or (c) or as a surviving divorced spouse under section 202 (e) or (f) for any month, the benefit to which he or she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced spouse or surviving divorced spouse were entitled to benefits for such month.

(4) In any case in which benefits are reduced pursuant to the preceding provisions of this subsection, the reduction shall be made after any deductions under this section and after any deductions under sec-

tion 222(b). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased.

(5) Notwithstanding any other provision of law, when—

(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection are applicable to such monthly benefits, and

(B) such individual's primary insurance amount is increased for the following month under any provision of this title, then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 202(q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202(q)) payable on the basis of such wages and self-employment income for such particular month.

(6) Notwithstanding any of the preceding provisions of this subsection other than paragraphs (3)(A), (3)(C), and (5) (but subject to section 215(i)(2)(A)(ii)), the total monthly benefits to which beneficiaries may be entitled under sections 202 and 223 for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, whether or not such total benefits are otherwise subject to reduction under this subsection but after any reduction under this subsection which would otherwise be applicable, shall be, reduced or further reduced (before the application of section 224) to the smaller of—

(A) 85 percent of such individual's average indexed monthly earnings (or 100 percent of his primary insurance amount, if larger), or

(B) 150 percent of such individual's primary insurance amount.

(7) In the case of any individual who is entitled for any month to benefits based upon the primary insurance amounts of two or more insured individuals, one or more of which primary insurance amounts were determined under section 215(a) or 215(d) as in effect (without regard to the table contained therein) prior to January 1979 and one or more of which primary insurance amounts were determined under section 215(a) (1) or (4), or section 215(d), as in effect after December 1978, the total benefits payable to that individual and all other individuals entitled to benefits for that month based upon those primary insurance amounts shall be reduced to an amount equal to the product of 1.75 and the primary insurance amount that would be com-

puted under section 215(a)(1) for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined under section 230 for the year in which that month occurs.

(8) Subject to paragraph (7), this subsection as in effect in December 1978 shall remain in effect with respect to a primary insurance amount computed under section 215 (a) or (d), as in effect (without regard to the table contained therein) in December 1978, *modified by the application of section 215(a)(6) as in effect August 1981*, except that a primary insurance amount so computed with respect to an individual who first becomes eligible for an old-age or disability insurance benefit, or dies (before becoming eligible for such a benefit), after December 1978, shall instead be governed by this section as in effect after December 1978. *For purposes of the preceding sentence the parenthetical phrase immediately preceding the semicolon at the end of subsection (a)(2)(C) of this section as in effect in December 1978 shall be disregarded.*

(9) When—

(A) one or more persons were entitled (without the application of section 202(j)(1)) to monthly benefits under section 202 for May 1978 on the basis of the wages and self-employment income of an individual,

(B) the benefit of at least one such person for June 1978 is increased by reason of the amendments made by section 204 of the Social Security Amendments of 1977; and

(C) the total amount of benefits to which all such persons are entitled under such section 202 are reduced under the provisions of this subsection (or would be so reduced except for the first sentence of section 203(a)(4)),

then the amount of the benefit to which each such person is entitled for months after May 1978 shall be increased (after such reductions are made under this subsection) to the amount such benefits would have been if the benefit of the person or persons referred to in subparagraph (B) had not been so increased.

* * * * *

Computation of Primary Insurance Amount

Sec. 215. (a)(1)(A) The primary insurance amount of an individual shall (except as otherwise provided in this section) be equal to the sum of—

(i) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this clause by subparagraph (B),

(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (i) but do not exceed the amount established for purposes of this clause by subparagraph (B), and

(iii) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (ii),

[rounded in accordance with subsection (g), and thereafter**]** increased as provided in subsection (i).

(B) (i) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible of such benefits), in the calendar year 1979, the amount established for purposes of clause (i) and (ii) of subparagraph (A) shall be \$180 and \$1,085, respectively.

(ii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established with respect to the calendar year 1979 under clause (i) of this subparagraph and the quotient obtained by dividing—

(I) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209 (a)) reported to the Secretary of the Treasury or his delegate for the second calendar year preceding the calendar year for which the determination is made, by

(II) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year 1977.

(iii) Each amount established under clause (ii) for any calendar year shall be rounded to the nearest \$1, except that any amounts so established which is a multiple of \$0.50 but not of \$1 shall be rounded to the next higher \$1.

[(C) (i) No primary insurance amount computed under subparagraph (A) may be less than—

(I) the dollar amount set forth on the first line of column IV in the table of benefits contained in (or deemed to be contained in) this subsection as in effect in December 1978, rounded (if not a multiple of \$1) to the next higher multiple of \$1, or

(II) an amount equal to \$11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this subdivision under subsection (i), whichever is greater. No increase under subsection (i), except as provided in subsection (i) (2) (A), shall apply to the dollar amount specified in subdivision (I) of this clause.**]**

(C) (i) No primary insurance amount computed under subparagraph (A) may be less than an amount equal to \$11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this clause under subsection (i).

(ii) For purposes of clause (i) **[(II)]**, the term "years of coverage" with respect to any individual means the number (not exceeding 30) equal to the sum of (I) the number (not exceeding 14 and disregarding any fraction) determined by dividing (a) the total of the wages credited to such individual (including wages deemed to be paid prior to 1951 to such individual under section 217, compensation under the Railroad Retirement Act of 1937 prior to 1951 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 231) for years after 1936 and before 1951 by (b) \$900, plus (II) the number equal to the number of years after 1950 each of which is a computation base

year (within the meaning of subsection (b) (2) (B) (ii)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 217, compensation under the Railroad Retirement Act of 1937 or 1974 which is creditable to such individual pursuant to this title, and wages deemed to be paid to such individual under section 229) and self-employment income of not less than 25 percent of the maximum amount which, pursuant to subsection (e), may be counted for such year, or of not less than 25 percent of the maximum amount which could be so counted for such year (in the case of a year after 1977) if section 230 as in effect immediately prior to the enactment of the Social Security Amendments of 1977 had remained in effect without change.

(D) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula for computing benefits under this paragraph and for adjusting wages and self-employment income under subsection (b) (3) in the case of an individual who becomes eligible for an old-age insurance benefit, or (if earlier) becomes eligible for a disability insurance benefit or dies, in the following year, and the average of the total wages (as described in subparagraph (B) (ii) (I)) on which that formula is based. With the initial publication required by this subparagraph, the Secretary shall also publish in the Federal Register the average of the total wages (as so described) for each calendar year after 1950.

(2) (A) A year shall not be counted as the year of an individual's death or eligibility for purposes of this subsection or subsection (i) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit or benefits to which he was entitled during such 12 months).

(B) In the case of an individual who was entitled to a disability insurance benefit for any of the 12 months before the month in which he became entitled to an old-age insurance benefit, became reentitled to a disability insurance benefit, or died, the primary insurance amount for determining any benefit attributable to that entitlement, reentitlement, or death is the greater of—

(i) the primary insurance amount upon which such disability insurance benefit was based, increased by the amount of each general benefit increase (as defined in subsection (i) (3)), and each increase provided under subsection (i) (2), that would have applied to such primary insurance amount had the individual remained entitled to such disability insurance benefit until the month in which he became so entitled or reentitled or died, or

(ii) the amount computed under paragraph (1) (C).

(C) In the case of an individual who was entitled to a disability insurance benefit for any month, and with respect to whom a primary insurance amount is required to be computed at any time after the close of the period of the individual's disability (whether because of such individual's subsequent entitlement to old-age insurance benefits or to a disability insurance benefit based upon a subsequent period of disability, or because of such individual's death), the primary insurance amount so computed may in no case be less than the primary

insurance amount with respect to which such former disability insurance benefit was most recently determined.

(3) (A) Paragraph (1) applies only to an individual who was not eligible for an old-age insurance benefit prior to January 1979 and who in that or any succeeding month—

- (i) becomes eligible for such a benefit,
- (ii) becomes eligible for a disability insurance benefit, or
- (iii) dies,

and (except for subparagraph (C) (i) [(II)] thereof) it applies to every such individual except to the extent otherwise provided by paragraph (4).

(B) For purposes of this title, an individual is deemed to be eligible—

- (i) for old-age insurance benefits, for months beginning with the month in which he attains age 62, or
- (ii) for disability insurance benefits, for months beginning with the month in which his period of disability began as provided under section 216(i) (2) (C),

except as provided in paragraph (2) (A) in cases where fewer than 12 months have elapsed since the termination of a prior period of disability.

(4) Paragraph (1) (except for subparagraph (C) (i) [(II)] thereof) does not apply to the computation or recomputation of a primary insurance amount for—

(A) an individual who was eligible for a disability insurance benefit for a month prior to January 1979 unless, prior to the month in which occurs the event described in clause (i), (ii), or (iii) of paragraph (3) (A), there occurs a period of at least 12 consecutive months for which he was not entitled to a disability insurance benefit, or

(B) an individual who had wages or self-employment income credited for one or more years prior to 1979, and who was not eligible for an old-age or disability insurance benefit, and did not die, prior to January 1979, if in the year for which the computation or recomputation would be made the individual's primary insurance amount would be greater if computed or recomputed—

- (i) under section 215(a) as in effect in December 1978, for purposes of old-age insurance benefits in the case of an individual to whom such section applies
- (ii) as provided by section 215(d), in the case of an individual to whom such section applies

In determining whether an individual's primary insurance amount would be greater if computed or recomputed as provided in subparagraph (B), (I) the table of benefits in effect in December 1978, *as modified by paragraph (6) as in effect for August 1981*, shall be applied without regard to any increases in that table which may become effective (in accordance with subsection (i) (4)) for years after 1978 (subject to clause (iii) of subsection (i) (2) (A) [but without regard to clauses (iv) and (v) thereof]) and (II) such individual's average monthly wage shall be computed as provided by subsection (b) (4).

(5) For purposes of computing the primary insurance amount (after December 1978) of an individual to whom paragraph (1) does

not apply (other than an individual described in paragraph (4) (B)), this section as in effect in December 1978 shall remain in effect, except that, effective for January 1979, the dollar amount specified in paragraph (3) of subsection (a) shall be increased to \$11.50, and, effective for months after July 1981, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be modified as specified in paragraph (6). The table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978, modified by the application of paragraph (6) as in effect in August 1981, shall be revised as provided by subsection (i) for each year after 1978.

(6) (A) *The table of benefits in effect in December 1978 under this section, referred to in paragraph (4) in the matter following subparagraph (B) and in paragraph (5), revised as provided by subsection (i), as applicable, shall be extended for average monthly wages of less than \$76.00 and primary insurance benefits (as determined under subsection (d)) of less than \$16.20.*

(B) *The Secretary shall determine and promulgate in regulations the methodology for extending the table under subparagraph (A).*

* * * * *

Recomputation of Benefits

(f) (1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in this subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 217(b).

(2) (A) If an individual has wages or self-employment income for a year after 1978 for any part of which he is entitled to old-age or disability insurance benefits, the Secretary shall, at such time or times and within such period as he may by regulation prescribe, recompute the individual's primary insurance account for that year.

(B) For the purpose of applying subparagraph (A) of subsection (a) (1) to the average indexed monthly earnings of an individual to whom that subsection applies and who receives a recomputation under this paragraph, there shall be used, in lieu of the amounts established by subsection (a) (1) (B) for purposes of clauses (i) and (ii) of subsection (a) (1) (A), the amounts so established that were (or, in the case of an individual described in subsection (a) (4) (B), would have been) used in the computation of such individual's primary insurance amount prior to the application of this subsection.

(C) A recomputation of any individual's primary insurance amount under this paragraph shall be made as provided in subsection (a) (1) as though the year with respect to which it is made is the last year of the period specified in subsection (b) (2) (B) (ii); and subsection (b) (3) (A) shall apply with respect to any such recomputation as it applied in the computation of such individual's primary insurance amount prior to the application of this subsection.

(D) A recomputation under this paragraph with respect to any year shall be effective—

(i) in the case of an individual who did not die in that year, for monthly benefits beginning with benefits for January of the following year; or

(ii) in the case of an individual who died in that year, for monthly benefits beginning with benefits for the month in which he died.

(3) [Repealed.]

(4) A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least \$1.

(5) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained age 65, the Secretary shall recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance benefits in the month in which he died; except that (i) his computation base years referred to in subsection (b) (2) shall include the year in which he died, and (ii) his elapsed years referred to in subsection (b) (3) shall not include the year in which he died or any year thereafter. Such recomputation of such primary insurance amount shall be effective for and after the month in which he died.

(6) Upon the death after 1967 of an individual entitled to benefits under section 202(a) or section 223, if any person is entitled to monthly benefits or a lump-sum death payment, on the wages and self-employment income of such individual, the Secretary shall recompute the decedent's primary insurance amount, but only if the decedent during his lifetime was paid compensation which was treated under section 205 (o) as remuneration for employment.

(7) This subsection as in effect in December 1978 shall continue to apply to the recomputation of a primary insurance amount computed under subsection (a) or (d) as in effect (without regard to the table in subsection (a)) in that month, and, where appropriate, under subsection (d) as in effect in December 1977. For purposes of recomputing a primary insurance amount determined under subsection (a) or (d) (as so in effect) in the case of an individual to whom those subsections apply by reason of subsection (a) (4) (B) as in effect after December 1978, no remuneration shall be taken into account for the year in which the individual initially became eligible for an old-age or disability insurance benefit or died, or for any year thereafter. *Effective August 1981, the recomputation shall be modified by the application of section 215 (a) (6) as in effect in August 1981, where applicable.*

(8) The Secretary shall recompute the primary insurance amounts applicable to beneficiaries whose benefits are based on a primary insurance amount which was computed under subsection (a) (3) effective prior to January 1979, or would have been so computed if the dollar amount specified therein were \$11.50. Such recomputation shall be effective January 1979, and shall include the effect of the increase in the dollar amount provided by subsection (a) (1) (C) (i) **[(II)]**. Such primary insurance amount shall be deemed to be provided under such section for purposes of subsection (i).

Rounding of Benefits

[(g)] The amount of any primary insurance amount and the amount of any monthly benefit computed under section 202 or 223 which (after reduction under section 203(a) and deductions under section 203(b)) is not a multiple of \$0.10 shall be raised to the next higher multiple of \$0.10.]

(g) *The amount of any monthly benefit computed under section 202 or 225 which (after any reduction under sections 203(a) and 224 and any deduction under section 203(b), and after any deduction under section 1840(a)(1)) is not a multiple of \$1 shall be rounded to the next lower multiple of \$1.*

* * * * *

Cost-of-Living Increases in Benefits

(i) (1) For purposes of this subsection—

(A) the term “base quarter” means (i) the calendar quarter ending on March 31 in each year after 1974, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this title;

(B) the term “cost-of-living computation quarter” means a base quarter, as defined in subparagraph (A)(i), in which the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, such Index in the later of (i) the last prior cost-of-living computation quarter which was established under this subparagraph, or (ii) the most recent calendar quarter in which occurred the effective month of a general benefit increase under this title; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective; and

(C) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2) (A) (i) The Secretary shall determine each year beginning with 1975 (subject to the limitation in paragraph (1)(B)) whether the base quarter (as defined in paragraph (1)(A)(i)) in such year is a cost-of-living computation quarter.

(ii) If the Secretary determines that the base quarter in any year is a cost-of-living computation quarter, he shall, effective with the month of June of that year as provided in subparagraph (B), increase—

(I) the benefit amount to which individuals are entitled for that month under section 227 or 228,

(II) the primary insurance amount of each other individual on which benefit entitlement is based under this title [(including a primary insurance amount determined under subsection (a)(1)(C)(i)(I), but subject to the provisions of such subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph)], and

(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 203 (and such total shall be increased, unless otherwise so increased under another provision of this title, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect without regard to the table contained therein) prior to January 1979, the amount

to which the beneficiaries may be entitled under section 203 as in effect in December 1978, except as provided by section 203(a) (7) and (8) as in effect after December 1978.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I), (II), and (III) (including each of those amounts as previously increased under this subparagraph) by the same percentage (rounded to the nearest one-tenth of 1 percent) as the percentage by which the Consumer Price Index for that cost-of-living computation quarter exceeds such index for the most recent prior calendar quarter which was a base quarter under paragraph (1)(A)(ii) or, if later, the most recent cost-of-living computation quarter under paragraph (1)(B). **¶** and any amount so increased that is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10. **¶** Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i) **¶**(II) **¶** of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Secretary under the last sentence of subparagraph (D)).

(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause (ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this title **¶**and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph **¶**) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after May of that year.

¶(iv)(I) In the case of an individual who is entitled to an old-age insurance benefit that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

¶(II) In the case of an individual who is entitled to an insurance benefit under subsection (e) or (f) of section 202 that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year (except as provided in subdivision (III)) before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

[(III) Any increase under this subsection which would otherwise be applied to a primary insurance amount except for the provisions of subdivision (II) of this clause, shall apply to such primary insurance amount if, during any month of the year in which the increase occurs, any individual is entitled to a benefit under subsection (d), (g), or (h) of section 202 based on such primary insurance amount, and such primary insurance amount is based upon the wages and self-employment income of a deceased individual.]

[(IV) No primary insurance amount determined under subsection (a)(1)(C)(i)(I) shall be increased under this subsection for any year during which no individual was entitled to any benefit based thereon under section 202 or 223 for any month of such year.]

[(V) In any case in which an increase under this subsection which occurs during any year applies to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), and such an increase occurring in a later year does not apply to such primary insurance amount on account of the provisions of this clause, any such increase which occurs in a later year which is applicable to such primary insurance amount shall be based upon such primary insurance amount as previously increased under this subsection.]

[(v) Notwithstanding clause (iv), no primary insurance amount shall be less than that provided under section 215(a)(1) without regard to subparagraph (C)(i)(I) thereof, as subsequently increased by applicable increases under this section.]

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after May of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after May of such calendar year.

(C)(i) Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1)(A)(ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance.

(ii) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

(D) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register within 45 days after the close of such quarter a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at

that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C) (i) [(II)] of subsection (a) (1) (with such revised primary insurance amounts constituting the increased amounts determined for purposes of such subparagraph (C) (i) [(II)] under this subsection), or specified in subsection (a) (3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 203(a) except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)). Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 203(a) (as added by section 101(a) (3) of the Social Security Disability Amendments of 1980).

(3) As used in this subsection, the term "general benefit increase under this title" means an increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this title are based.

(4) This subsection as in effect in December 1978, *modified by the application of subsection (a) (6) as in effect in August 1981*, shall continue to apply to subsections (a) and (d), as then in effect, for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, *modified by the application of subsection (a) (6) as in effect in August 1981*, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4) (B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)), *except that for this purpose the last sentence in paragraph (2) (A) (ii), (2) (D) (iv), and (2) (D) (v) of this subsection as in effect in December 1978 shall be disregarded*. For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4) (B) applies), the Secretary shall publish in the Federal Register revisions of the table of benefits contained in subsection (a), as in effect in December 1978, *modified by the application of subsection (a) (6) as in effect in August 1981*, as required by paragraph (2) (D) of this subsection as then in effect.

* * * * *

Other Definitions

Sec. 216. * * *

Disability; Period of Disability

(i) (1) Except for purposes of section 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which is accompanied by a limitation in the field of vision such that the widest diameter of the visual field

subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2) (A), (3), (4), (5), and (6) of section 223(d) shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2) (A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than five full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains the age of 65.

In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died.

(C) A period of disability shall begin—

(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains age 65, or (ii) the month preceding (I) the termination month (as defined in section 223(a)(1)), or, if earlier (II) the first month for which no benefit is payable by reason of section 223(e), where no benefit is payable for any of the succeeding months during the 15-month period referred to in such section.

(E) Except as is otherwise provided in subparagraph (F), no application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraphs (B) and (E)) shall be accepted as an application for purposes of this paragraph if—

(i) in the case of an application filed by or on behalf of an individual with respect to a disability which ends after the month in which the Social Security Amendments of 1967 is enacted, such application is filed not more than 36 months after the month in which such disability ended, such individual is alive at the time the application is filed, and the Secretary finds in accordance with regulations prescribed by him that the failure of such individual to file an application for a disability determination within the time specified in subparagraph (E) was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application, and

(ii) in the case of an application filed by or on behalf of an individual with respect to a period of disability which ends in or before the month in which the Social Security Amendments of 1967 as enacted,

(I) such application is filed not more than 12 months after the month in which the Social Security Amendments of 1967 is enacted,

(II) a previous application for a disability determination has been filed by or on behalf of such individual (1) in or before the month in which the Social Security Amendments of 1967 is enacted, and (2) not more than 36 months after the month in which his disability ended, and

(III) the Secretary finds in accordance with regulations prescribed by him, that the failure of such individual to file an application within the then specified time period was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application.

In making a determination under this subsection, with respect to the disability or period of disability of any individual whose application for a determination thereof is accepted solely by reason of the provisions of this subparagraph (F), the provisions of this subsection (other than the provisions of this subparagraph) shall be applied as such provisions are in effect at the time such determination is made.

(G) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application (and shall be deemed to have been filed on such first day) only if the applicant satisfies the requirements for a period of disability before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearings is made (regardless of whether such decision becomes the final decision of the Secretary).

(3) The requirements referred to in clauses (i) and (ii) of paragraph (2) (C) are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such quarter; **[and]**

(B) (i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with such quarter, or

(ii) if such quarter ends before he attains (or would attain) age 31 not less than one-half (and not less than 6) of the quarters during the period ending with such quarter and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in paragraph (1)) [J]; and

(C) *he had not less than six quarters of coverage during the thirteen-quarter period which ends with the quarter in which such month occurred.*

For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and *for purposes of subparagraphs (B) and (C) a quarter shall not be counted as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage.*

(4) [Repealed.]

Benefits in Case of Veterans

Sec. 217.

(a) * * *

(b) (1) Any World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 215(c) as in effect in December 1978, *and as modified by the application of section 215(a) (6) as in effect in August 1981.* Notwithstanding section 215(d) as in effect in December 1978, the primary insurance benefit (for purposes of section 215(c) as in effect in December 1978) of such veteran shall be determined as provided in this title as in effect prior to the enactment of this section, except that the 1 per centum addition provided for in section 209(e) (2) of this Act as in effect prior to the enactment of this section shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Veterans' Administration to be payable by it on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary of Health, Education, and Welfare shall make a decision without regard to paragraph (1) (B) of this subsection unless he has been notified by the Veterans' Administration that pension or compensation is determined to be payable by the Veterans' Administration by reason of the death of such veteran. The Secretary of Health, Education, and Welfare shall thereupon report such decision to the Veterans' Administration. If the Veterans' Administration in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, it shall notify the Secretary of Health, Education, and Welfare, and the Secretary shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payment theretofore certified by the Secretary of Health, Education, and Welfare on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Veterans' Administration, shall (notwithstanding the provisions of section 3101 of title 38, United States Code) be deemed to have been paid to him by such Administration on account of such accrued pension or compensation. No such payment certified by the Secretary of Health, Education, and Welfare, and no payment certified by him for any month prior to the first month for which any pension or compensation is paid by the Veterans' Administration shall be deemed by reason of this subsection to have been an erroneous payment.

* * * * *

Rehabilitation Services

Referral for Rehabilitation Services

Sec. 222. (a) * * *

[Costs of Rehabilitation Services From Trust Funds

[(d) For the purpose of making vocational rehabilitation services more readily available to disabled individuals who are—

[(A) entitled to disability insurance benefits under section 223, or

[(B) entitled to child's insurance benefits under section 202 (d) after having attained age 18 (and are under a disability), or

[(C) entitled to widow's insurance benefits under section 202 (e) prior to attaining age 60, or

[(D) entitled to widower's insurance benefits under section 202 (f) prior to attaining age 60,

to the end that savings will result to the Trust Fund as a result of rehabilitating the maximum number of such individuals into productive activity, there are authorized to be transferred from the Trust Funds such sums as may be necessary to enable the Secretary to pay the costs of vocational rehabilitation services for such individuals

(including (i) services during their waiting periods, and (ii) so much of the expenditures for the administration of any State plan as is attributable to carrying out this subsection); except that the total amount so made available pursuant to this subsection may not exceed—

[(i) 1 percent in the fiscal year ending June 30, 1972,

[(ii) 1.25 percent in the fiscal year ending June 30, 1973,

[(iii) 1.5 percent in the fiscal year ending June 30, 1974, and thereafter,

of the total of the benefits under section 202(d) for children who have attained age 18 and are under a disability, the benefits under section 202(e) for widows and surviving divorced wives who have not attained age 60 and are under a disability, the benefits under section 202(f) for widowers who have not attained age 60, and the benefits under section 223, which were certified for payment in the preceding year. The selection of individuals (including the order in which they shall be selected) to receive such services shall be made in accordance with criteria formulated by the Secretary which are based upon the effect the provision of such services would have upon the Trust Funds.

[(2) In the case of each State which is willing to do so, such vocational rehabilitation services shall be furnished under a State plan for vocational rehabilitation services which—

[(A) has been approved under section 5 of the Vocational Rehabilitation Act,

[(B) provides that, to the extent funds provided under this subsection are adequate for the purpose, such services will be furnished, to any individual in the State who meets the criteria prescribed by the Secretary pursuant to paragraph (1), with reasonable promptness and in accordance with the order of selection determined under such criteria, and

[(C) provides that such services will be furnished to any individual without regard to (i) his citizenship or place of residence, (ii) his need for financial assistance except as provided in regulations of the Secretary in the case of maintenance during rehabilitation, or (iii) any order of selection which would otherwise be followed under the State plan pursuant to section 5(a)(4) of the Vocational Rehabilitation Act.

[(3) In the case of any State which does not have a plan which meets the requirements of paragraph (2), the Secretary may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

[(4) Payments under this subsection may be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

[(5) Money paid from the Trust Funds under this subsection to pay the costs of providing services to individuals who are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid out from the Trust Funds under this subsection shall be

charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

[(A) the total cost of the services provided under this subsection, and

[(B) subject to the provisions of the preceding sentence, the amount of such cost which should be charged to each of such Trust Funds.

[(6) For the purposes of this subsection the term “vocational rehabilitation services” shall have the meaning assigned to it in the Vocational Rehabilitation Act, except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purposes of this subsection.】

Disability Insurance Benefit Payments

Disability Insurance Benefits

Sec. 223. (a) * * *

Definitions of Insured Status and Waiting Period

(c) For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such month [and];

(B) (i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or

(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with the quarter in which such month occurred and beginning after he attained age 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage; and

(C) *he had not less than six quarters of coverage during the thirteen-quarter period which ends with the quarter in which such month occurred;*

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of “blindness” as defined in section 216(i)(1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and *for purposes of subparagraphs (B) and (C) a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.*

(2) The term “waiting period” means, in the case of any application for disability insurance benefits, the earliest period of five consecutive calendar months—

(A) throughout which the individual with respect to whom such application is filed has been under a disability, and

(B) (i) which begins not earlier than with the first day of the seventeenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such seventeenth month, or (ii) if he is not so insured in such month, which begins not earlier than the first day of the first month after such seventeenth month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

* * * * *

Reduction of Benefits Based on Disability [on Account of Receipt of Workmen's Compensation]

Sec. 224. (a) If for any month prior to the month in which an individual attains the age of [62] 65—

(1) such individual is entitled to benefits under section 223, and

[(2) such individual is entitled for such month, under a workmen's compensation law or plan of the United States or a State to periodic benefits for a total or partial disability (whether or not permanent), and the Secretary has, in a prior month, received notice of such entitlement for such month.]

(2) such individual is entitled for such month, under a law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b) (2)), or an instrumentality of two or more States (as that term is used in section 218(k)), to periodic benefits (other than benefits payable under title 38, United States Code, benefits payable under a program of assistance which is based on need, benefits based on service all or part of which was included under an agreement entered into by a State and the Secretary under section 218, and benefits under a law or plan of the United States based on service all, or substantially all, of which is employment as defined in section 210) on account of such individual's total or partial disability (whether or not permanent),

the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(3) such total of benefits under sections 223 and 202 for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under [the workmen's compensation law or plan,] *such laws or plans,*

exceeds the higher of—

(5) 80 per centum of his "average current earnings", or

(6) the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and

self-employment income, prior to reduction under this section. In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month (in a continuous period of months) reduce such total below the sum of—

(7) the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

For purposes of clause (5), an individual's average current earnings means the largest of (A) the average monthly wage (determined under section 215(b) as in effect prior to January 1979) used for purposes of computing his benefits under section 223, (B) one-sixtieth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a) and 211(b)(1)) for the five consecutive calendar years after 1950 for which such wages and self-employment income were highest, or (C) one-twelfth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a) and 211(b)(1)) for the calendar year in which he had the highest such wages and income during the period consisting of the calendar year in which he became disabled (as defined in section 223(d)) and the five years preceding that year.

(b) If any periodic benefit [under a workmen's compensation law or plan] *for a total or partial disability under a law or plan described in subsection (a)(2)* is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate as nearly as practicable the reduction prescribed by subsection (a).

(c) Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 203, but before deductions under such section and under section 222(b).

(d) The reduction of benefits required by this section shall not be made if the [workmen's compensation] law or plan *described in subsection (a)(2)* under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title on the basis of the wages and self-employment income of an individual entitled to benefits under section 223, *and such law or plan so provided on February 18, 1981.*

(e) If it appears to the Secretary that an individual may be eligible for periodic benefits under a [workmen's compensation] law or plan which would give rise to reduction under this section, he may require, as a condition of certification for payment of any benefits under section 223 to any individual for any month and of any benefits under section

202 of such month based on such individual's wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Secretary may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205 (i).

* * * * *

(h) (1) *Notwithstanding any other provision of law, the head of any Federal agency shall provide such information within its possession as the Secretary may require for purposes of making a timely determination of the amount of the reduction, if any, required by this section in benefits payable under this title, or verifying other information necessary in carrying out the provisions of this section.*

(2) *The Secretary is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plans subject to the provisions of this section in order to obtain such information as he may require to carry out the provisions of this section.*

* * * * *

International Agreements

Purpose of Agreement

Sec. 233. (a) * * *

Crediting Periods of Coverage; Conditions of Payment of Benefits

(c) (1) Any agreement establishing a totalization arrangement pursuant to this section shall provide—

(A) that in the case of an individual who has at least 6 quarters of coverage as defined in section 213 of this Act and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this title and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this title;

(B) (i) that employment or self-employment, or any service which is recognized as equivalent to employment or self-employment under this title or the social security system of a foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this title or under the system established under the laws of such foreign country, but not under both, and (ii) the methods and conditions for determining under which system employment, self-employment, or other service shall result in a period of coverage; and

(C) that where an individual's periods of coverage are combined, the benefit amount payable under this title shall be based

on the proportion of such individual's periods of coverage which was completed under this title.

[(2) Any such agreement may provide that—

[(A) an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement; and

[(B) the benefit paid by the United States to an individual who legally resides in the United States shall, if less when added to the benefit paid by such foreign country than the benefit amount which would be payable to an entitled individual based on the first figure in (or deemed to be in) column IV of the table in section 215(a) in the case of an individual becoming eligible for such benefit before January 1, 1979, or based on a primary insurance amount determined under section 215(a)(1)(C)(i)(I) in the case of an individual becoming eligible for such benefit on or after that date, be increased so that the total of the two benefits is equal to the benefit amount which would be so payable.]

(2) *Any such agreement may provide that an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement.*

* * * * *

(3) Section 226 shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

(4) any such agreement may contain other provisions which are not inconsistent with the other provisions of this title and which the President deems appropriate to carry out the purposes of this section.

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

Part A—Aid to Families With Dependent Children Appropriation

* * * * *

State Plans for Aid and Services to Needy Families With Children

Sec. 402. (a) A State plan for aid and services to needy families with children must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with

dependent children is denied or is not acted upon with reasonable promptness;

(5) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan; and

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

[(7) except as may be otherwise provided in clause (8), provide that the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid, as well as any expenses reasonably attributable to the earning of any such income;]

(7) *except as may be otherwise provided in paragraph (8) or (31), provide that the State agency—*

(A) shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid;

(B) shall determine ineligible for aid any family the combined value of whose resources (reduced by any obligations or debts with respect to such resources) exceeds \$1,000 or such lower amount as the State may determine, but not including as a resource for purposes of this subparagraph a home owned and occupied by such child, relative, or other individual and so much of the family member's ownership interest in one automobile as does not exceed such amount as the Secretary may prescribe; and

(C) may, in the case of a family claiming or receiving aid under this part for any month, take into consideration as income (to the extent the State determines appropriate, as specified in such plan, and notwithstanding any other provision of law)—

(i) an amount not to exceed the value of the family's monthly allotment of food stamp coupons, to the extent such value duplicates the amount for food included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income; and

(ii) an amount not to exceed the value of any rent or housing subsidy provided to such family, to the extent such value duplicates the amount for housing included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income;

[(8) provide that, in making the determination under clause (7), the State agency—

[(A) shall with respect to any month disregard—

[(i) all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment, and

[(ii) in the case of earned income of a dependent child not included under clause (i), a relative receiving such aid, and any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$30 of the total of such earned income for such month plus one-third of the remainder of such income for such month (except that the provisions of this clause (ii) shall not apply to earned income derived from participation on a project maintained under the programs established by section 432(b) (2) and (3)); and

[(B) (i) may, subject to the limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child, and (ii) may, before disregarding the amounts referred to in subparagraph (A) and clause (i) of this subparagraph, disregard not more than \$5 per month of any income; except that, with respect to any month, the State agency shall not disregard any earned income (other than income referred to in subparagraph (B)) of—

[(C) any one of the persons specified in clause (ii) of subparagraph (A) if such person—

[(i) terminated his employment or reduced his earned income without good cause within such period (of not less than 30 days) preceding such month as may be prescribed by the Secretary; or

[(ii) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employment is determined by the State or local agency administering the State plan, after notification by him, to be a bona fide offer of employment; or

[(D) any of such persons specified in clause (ii) of subparagraph (A) if with respect to such month the income of the persons so specified (within the meaning of clause (7)) was in excess of their need as determined by the State agency pursuant to clause (7) (without regard to clause (8)), unless, for any one of the four months preceding such month, the needs of such person were met by the furnishing of aid under the plan; or

[(E) any of the persons specified in clause (ii) of subparagraph (A) with respect to which there is a failure without good

cause to make a timely report (as prescribed by the State plan) to the State agency;]

(8) (A) provide that, with respect to any month, in making the determination under paragraph (7), the State agency—

(i) shall disregard all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or a part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment;

(ii) shall disregard from the earned income of any child or relative applying for or receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first \$75 of the total of such earned income for such month (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month);

(iii) shall disregard from the earned income of any child, relative, or other individual specified in clause (ii), an amount equal to expenditures for care in such month for a dependent child, or an incapacitated individual living in the same home as the dependent child, receiving aid to families with dependent children and requiring such care for such month, to the extent that such amount (for each such dependent child or incapacitated individual) does not exceed \$160 (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month); and

“(iv) shall disregard from the earned income of any child or relative receiving aid to families with dependent children, or of any other individual living in the same home as such relative and child, whose needs are taken into account in making such determination, an amount equal to the first \$30 of the total of such earned income not already disregarded under the preceding provisions of this paragraph plus one-third of the remainder thereof (but excluding, for purposes of this subparagraph, earned income derived from participation on a project maintained under the programs established by section 432(b)(2) and (3)); and
(B) provide that (with respect to any month) the State agency—

(i) shall not disregard, under clause (ii), (iii), or (iv) of subparagraph (A), any earned income of any one of the persons specified in subparagraph (A) (ii) of such person—

(I) terminated his employment or reduced his earned income without good cause within such period (of not less than thirty days) preceding such month as may be prescribed by the Secretary;

(II) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such em-

ployer is determined by the State or local agency administering the State plan, after notification by the employer, to be a bona fide offer of employment; or

(III) failed without good cause to make a timely report (as prescribed by the State plan pursuant to paragraph (14)) to the State agency of earned income received in such month; and

(ii) (I) shall not disregard, under subparagraph (A) (iv), any earned income of any of the persons specified in subparagraph (A) (ii), if, with respect to such month, the income of the persons so specified was in excess of their need, as determined by the State agency pursuant to paragraph (7) (without regard to subparagraph (A) (iv) of this paragraph), unless the persons received aid under the plan in 1 or more of the four months preceding such month and subparagraph (A) (iv) has not already been applied to their income for four consecutive months while they were receiving aid under the plan; and

(II) in the case of the earned income of a person with respect to whom subparagraph (A) (iv) has been applied for four consecutive months, shall not apply the provisions of subparagraph (A) (iv) for so long as he continues to receive aid under the plan and shall not apply such provisions to any month thereafter until the expiration of an additional period of twelve consecutive months during which he is not a recipient of such aid;

(9) provide safeguards which restrict the use of disclosure of information concerning applicants or recipients to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under [part B, C, or D] *part C or D* of this title or under title I, X, XIV, XVI, XIX, or XX, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assigned program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, and (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental entity which is authorized by law to conduct such audit or activity; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an entity referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient;

(10) provide, effective July 1, 1951, that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall, subject to paragraphs (25) and (26), be furnished with reasonable promptness to all eligible individuals;

(11) provide for prompt notice (including the transmittal of all relevant information) to the State child support collection agency (established pursuant to part D of this title) of the furnishing of aid to families with dependent children with respect to a child who has

been deserted or abandoned by a parent (including a child born out of wedlock without regard to whether the paternity of such child has been established);

(12) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act;

(13) provide that—

(A) except as provided in subparagraph (B), the State agency (i) will determine a family's eligibility for aid for a month on the basis of the family's income, composition, resources, and other similar relevant circumstances during such month, and (ii) will determine the amount of such aid on the basis of the income and other relevant circumstances in the first or, at the option of the State but only where the Secretary determines it to be appropriate, second month preceding such month; and

(B) in the case of the first month, or at the option of the State but only where the Secretary determines it to be appropriate, the first and second months, in a period of consecutive months for which aid is payable, the State agency will determine the amount of aid on the basis of the family's income and other relevant circumstances in such first or second month;

(14) provide that the State agency will require each family to which it furnishes aid to families with dependent children (or to which it would provide such aid but for paragraph (22) or (32)) to report, as a condition to the continued receipt of such aid (or to continue to be deemed to be a recipient of such aid), each month to the State agency on—

(A) the income received, family composition, and other relevant circumstances during the prior month; and

(B) the income and resources it expects to receive, or any changes in circumstances affecting continued eligibility or benefit amount, that it expects to occur, in that month (or in future months);

and that, in addition to whatever action may be appropriate based on other reports or information received by the State agency, the State agency will take prompt action to adjust the amount of assistance payable, as may be appropriate, on the basis of the information contained in the report (or upon the failure of the family to furnish a timely report), and will give an appropriate explanatory notice, concurrent with its action, to the family;

(15) provide [as part of the program of the State for the provision of services under title XX] (A) for the development of a program, for each appropriate relative and dependent child receiving aid under the plan and for each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under clause (7), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are

offered to them and are provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services, but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and (B) to the extent that services provided under this clause [or clause (14)] are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services;

(16) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have;

(17) *provide that if a person specified in paragraph (8) (A) (i) or (ii) receives in any month an amount of income which, together with all other income for that month not excluded under paragraph (8), exceeds the State's standard of need applicable to the family of which he is a member—*

(A) such amount of income shall be considered income to such individual in the month received, and the family of which such person is a member shall be ineligible for aid under the plan for the whole number of months that equals (i) the sum of such amount and all other income received in such month, not excluded under paragraph (8), divided by (ii) the standard of need applicable to such family, and

(B) any income remaining (which amount is less than the applicable monthly standard) shall be treated as income received in the first month following the period of ineligibility specified in subparagraph (A);

(18) *provide that no family shall be eligible for aid under the plan for any month if, for that month, the total income of the family (other than payments under the plan), without application of paragraph (8), exceeds 150 percent of the State's standard of need for a family of the same composition;*

(19) provide—

(A) that every individual, as a condition of eligibility for aid under this part, shall register for manpower services, training, employment, and other employment-related activities (including employment search, not to exceed eight weeks in total in each year) with the Secretary of Labor as provided by regulations issued by him, unless such individual is—

[(i) a child who is under age 16 or attending school full time;]

(i) a child who is under age 16 or attending, full-time, an elementary, secondary, or vocational (or technical) school;

(ii) a person who is ill, incapacitated, or of advanced age;

(iii) a person so remote from a work incentive project that his effective participation is precluded;

(iv) a person whose presence in the home is required because of illness or incapacity of another member of the household;

[(v) a mother or other relative of a child under the age of six who is caring for the child;]

(v) *the parent or other relative of a child under the age of six who is personally providing care for the child with only very brief and infrequent absences from the child:*

(vi) the [mother or other female caretaker of a child, if the father or another adult male relative] *parent or other caretaker of a child who is deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, if another adult relative is in the home and not excluded by clause (i), (ii), (iii), or (iv) of this subparagraph (unless he has failed to register as required by this subparagraph, or has been found by the Secretary of Labor to have refused without good cause to participate under a work incentive program or accept employment as described in subparagraph (F) of this paragraph) ; [or]*

(vii) a person who is working not less than 30 hours per week; *or*

(viii) *the parent of a child who is deprived of parental support or care by reason of the unemployment of a parent, if the other parent (who is the principal earner, as defined in section 407(d)) is not excluded by the preceding clauses of this subparagraph;*

and that any individual referred to in clause (v) shall be advised of [her] *his* option to register, if [she] *he* so desires, pursuant to this paragraph, and shall be informed of the child care services (if any) which will be available to [her] *him* in the event [she] *he* should decide so to register;

(B) that aid to families with dependent children under the plan will not be denied by reason of such registration or the individual's certification to the Secretary of Labor under subparagraph (G) of this paragraph, or by reason of an individual's participation on a project under the program established by section 432(b) (2) or (3);

(C) for arrangements to assure that there will be made a non-Federal contribution to the work incentive programs established by part C by appropriate agencies of the State or private organizations of 10 per centum of the cost of such programs, as specified in section 435(b);

(D) that (i) training incentives authorized under section 434 shall be disregarded in determining the needs of an individual under section 402(a) (7), and (ii) in determining such individual's needs the additional expenses attributable to his participation in a program established by section 432(b) (2) or (3) shall be taken into account;

(E) [Repealed].

(F) that if (and for such period as is prescribed under joint regulations of the Secretary and the Secretary of Labor) any

child, relative or individual has been found by the Secretary of Labor under section 433(g) to have refused without good cause to participate under a work incentive program established by part C with respect to which the Secretary of Labor has determined his participation is consistent with the purposes of such part C, or to have refused without good cause to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined, after notification by him, to be a bona fide offer of employment—

(i) if the relative makes such refusal, such relative's needs shall not be taken into account in making the determination under clause (7), and aid for any dependent child in the family in the form of payments of the type described in section 406(b) (2) (which in such a case shall be without regard to clauses (A) through (E) thereof) **[or section 408]** will be made;

(ii) *if the parent who has been designated as the principal earner, for purposes of section 407, makes such refusal, aid will be denied to all members of the family;*

[(ii)] (iii) aid with respect to a dependent child will be denied if a child who is the only child receiving aid in the family makes such refusal;

[(iii)] (iv) if there is more than one child receiving aid in the family, aid for any such child will be denied (and his needs will not be taken into account in making the determination under clause (7)) if that child makes such refusal; and

[(iv)] (v) if such individual makes such refusal, such individual's needs shall not be taken into account in making the determination under clause (7);

(G) that the State agency will have in effect a special program which (i) will be administered by a separate administrative unit (which will, to the maximum extent feasible, be located in the same facility as that utilized for the administration of programs established pursuant to section 432(b) (1), (2), or (3)) and the employees of which will, to the maximum extent feasible, perform services only in connection with the administration of such program, (ii) will provide (through arrangements with others or otherwise) for individuals who have been registered pursuant to subparagraph (A) of this paragraph (I) in accordance with the order of priority listed in section 433(a), such health, vocational rehabilitation, counseling, child care, and other social and supportive services as are necessary to enable such individuals to accept employment or receive manpower training provided under section 432(b) (1), (2), or (3), and will, when arrangements have been made to provide necessary supportive services, including child care, certify to the Secretary of Labor those individuals who are ready for employment or training under section 432(b) (1), (2), or (3), (II) such social and supportive services as are necessary to enable such individuals as determined appropriate by the Secretary of Labor actively to engage in other

employment-related (including but not limited to employment search) activities, as well as timely payment for necessary employment search expenses, and (III) for a period deemed appropriate by the Secretary of Labor after such an individual accepts employment, such social and supportive services as are reasonable and necessary to enable him to retain such employment, (iii) will participate in the development of operational and employability plans under section 433(b); and (iv) provides for purposes of clause (ii), that, when more than one kind of child care is available, the mother may choose the type, but she may not refuse to accept child care services if they are available; and

(H) that an individual participating in employment search activities shall not be referred to employment opportunities which do not meet the criteria for appropriate work and training to which an individual may otherwise be assigned under section 432(b) (1), (2), or (3);

[(20) provide that the State has in effect a State plan for foster care and adoption assistance approved under part E of this title;]

(21) provide—

(A) *that, for purposes of this part, participation in a strike shall not constitute good cause to leave, or to refuse to seek or accept employment; and*

(B) (i) *that aid to families with dependent children is not payable to a family for any month in which any caretaker relative with whom the child is living is, on the last day of such month, participating in a strike, and (ii) that no individual's needs shall be included in determining the amount of aid payable for any month to a family under the plan if, on the last day of such month, such individual is participating in a strike;*

(22) *provide that the State agency will promptly take all necessary steps to correct any overpayment or underpayment of aid under the State plan and, in the case of—*

(A) *an overpayment to an individual who is a current recipient of such aid, recovery will be made by repayment by the individual or by reducing the amount of any future aid payable to the family of which he is a member, except that such recovery shall not result in the reduction of aid payable for any month, such that the aid, when added to such family's liquid resources and to its income (without application of paragraph (8)), is less than 90 percent of the amount payable under the State plan to a family of the same composition with no other income (and, in the case of an individual to whom no payment is made for a month solely by reason of recovery of an overpayment, such individual shall be deemed to be a recipient of aid for such month);*

(B) *an overpayment to any individual who is no longer receiving aid under the plan, recovery shall be made by appropriate action under State law against the income or resources of the individual or the family; and*

(C) *an underpayment, the corrective payment shall be disregarded in determining the income of the family, and shall be disregarded in determining its resources in the month the corrective payment is made and in the following month;*

(23) provide that by July 1, 1969, the amounts used by the State to determine the needs of individuals will have been adjusted to reflect fully changes in living costs since such amounts were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted;

(24) provide that if an individual is receiving benefits under title XVI, then, for the period for which such benefits are received, such individual shall not be regarded as a member of a family for purposes of determining the amount of the benefits of the family under this title and his income and resources shall not be counted as income and resources of a family under this title;

(25) provide (A) that, as a condition of eligibility under the plan, each applicant for or recipient of aid shall furnish to the State agency his social security account number (or numbers, if he has more than one such number), and (B) that such State agency shall utilize such account numbers, in addition to any other means of identification it may determine to employ in the administration of such plan;

(26) provide that, as a condition of eligibility for aid, each applicant or recipient will be required—

(A) to assign the State any rights to support from any other person such applicant may have (i) in his own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid, and (ii) which have accrued at the time such assignment is executed,

(B) to cooperate with the State (i) in establishing the paternity of a child born out of wedlock with respect to whom aid is claimed, and (ii) in obtaining support payments for such applicant and for a child with respect to whom such aid is claimed, or in obtaining any other payments or property due such applicant or such child, unless (in either case) such applicant or recipient is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the child on whose behalf aid is claimed; and that if the relative with whom a child is living is found to be ineligible because of failure to comply with the requirements of subparagraphs (A) and (B) of this paragraph, any aid for which such child is eligible will be provided in the form of protective payments as described in section 406(b)(2) (without regard to subparagraphs (A) through (E) of such section);

(27) provide that the State has in effect a plan approved under part D and operate a child support program in conformity with such plan;

(28) provide that, in determining the amount of aid to which an eligible family is entitled, any portion of the amounts collected in any particular month as child support pursuant to a plan approved under part D, and retained by the State under section 457, which (under the State plan approved under this part as in effect both during July 1975 and during that particular month) would not have caused a reduction in the amount of aid paid to the family if such amounts had been paid directly to the family, shall be added to the amount of aid otherwise payable to such family under the State plan approved under this part;

(29) effective October 1, 1979, provide that wage information available from the Social Security Administration under the provisions of section 411 of this Act, and wage information available (under the provisions of section 3304(a)(16) of the Federal Unemployment Tax Act) from agencies administering State unemployment compensation laws, shall be requested and utilized to the extent permitted under the provisions of such sections; except that the State shall not be required to request such information from the Social Security Administration where such information is available from the agency administering the State unemployment compensation laws; [and]

(30) at the option of the State, provide for the establishment and operation, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under subsection (d), of an automated statewide management information system designed effectively and efficiently, to assist management in the administration of the State plan for aid to families with dependent children approved under this part, so as (A) to control and account for (i) all the factors in the total eligibility determination process under such plan for aid (including but not limited to (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses, and mailing addresses (including postal ZIP codes), of all applicants and recipients of such aid and the relative with whom any child who is such an applicant or recipient is living) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether an individual is or has been receiving benefits from more than one jurisdiction, (II) checking records of applicants and recipients of such aid on a periodic basis with other agencies, both intro- and inter-State, for determination and verification of eligibility and payment pursuant to requirements imposed by other provisions of this Act), (ii) the costs, quality, and delivery of funds and services furnished to applicants for and recipients of such aid, (B) to notify the appropriate officials of child support, food stamp, social service, and medical assistance programs approved under title XIX whenever the case becomes ineligible or the amount of aid or services is changed, and (C) to provide for security against unauthorized access to, or use of, the data in such system [.] ;

(31) *provide that, in making the determination for any month under paragraph (7), the State agency shall take into consideration so much of the income of the dependent child's stepparent living in the same home as such child as exceeds the sum of (A) the first \$75 of the total of such stepparent's earned income for such month (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month), (B) the State's standard of need under such plan for a family of the same composition as the stepparent and those other individuals living in the same household as the dependent child and claimed by such stepparent as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making the determination under paragraph (7), (C) amounts*

paid by the stepparent to individuals not living in such household and claimed by him as dependents for purposes of determining his Federal personal income tax liability, and (D) payments by such stepparent of alimony or child support with respect to individuals not living in such household; and

(32) provide that no payment of aid shall be made under the plan for any month if the amount of such payment, as determined in accordance with the applicable provisions of the plan and of this part, would be less than \$10, but an individual with respect to whom a payment of aid under the plan is denied solely by reason of this paragraph is deemed to be a recipient of aid but shall not be eligible to participate in a community work experience program.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for aid to families with dependent children a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

(c) The Secretary shall, on the basis of his review of the reports received from the States under clause (15) of subsection (a), compile such data as he believes necessary and from time to time publish his findings as to the effectiveness of the programs developed and administered by the States under such clause. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the programs developed and administered by each State under such clause (15).

[(d) (1) For purposes of paragraphs (7) and (8) of subsection (a), any refund of Federal income taxes made by reason of section 43 of the Internal Revenue Code of 1954 (relating to earned income credit) and any payment made by an employer under section 3507 of such Code (relating to advance payment of earned income credit) shall be considered earned income.]

(d) (1) For purposes of this part, an individual's "income" shall also include, to the extent and under the circumstances prescribed by the Secretary, an amount (which shall be treated as earned income for purposes of this part) equal to the earned income advance amount (under section 3507(a) of the Internal Revenue Code of 1954) that is (or, upon the filing of an earned income eligibility certificate, would be) payable to such individual.

(2) In any case in which such advance payments for a taxable year made by all employers to an individual under section 3507 of such Code exceed the amount of such individual's earned income credit allowable under section 43 of such Code for such year, so that such individual is liable under section 43(g) of such Code for a tax equal to such excess, such individual's benefit amount must be appropriately adjusted so as to provide payment to such individual of an amount equal to the amount of the benefits lost by such individual on account of such excess advance payments.

(e)(1) The Secretary shall not approve the initial and annually updated advance automatic data processing planning document, referred to in subsection (a)(30), unless he finds that such document, when implemented, will generally carry out the objectives of the statewide management system referred to in such subsection, and such document—

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

(B) contains a description of the proposed statewide management system, including a description of information flows, input data, and output reports and uses,

(C) sets forth the security and interface requirements to be employed in such statewide management system,

(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

(E) includes cost-benefit analyses of each alternative management system, data processing services and equipment, and a cost allocation plan containing the basis for rates, both direct and indirect, to be in effect under such statewide management system,

(F) contains an implementation plan with charts of development events, testing descriptions, proposed acceptance criteria, and backup and fallback procedures to handle possible failure of contingencies, and

(G) contains a summary of proposed improvement of such statewide management system in terms of qualitative and quantitative benefits.

(2)(A) The Secretary shall, on a continuing basis, review, assess, and inspect the planning, design, and operation of, statewide management information systems referred to in section 403(a)(3)(B), with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under such section and the conditions specified under subsection (a)(30) of this section.

(B) If the Secretary finds with respect to any statewide management information system referred to in section 403(a)(3)(B) that there is a failure substantially to comply with criteria, requirements, and other undertakings, prescribed by the advance automatic data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.

Payment to States

Sec. 403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following

proportions of the total amounts expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof) —

(A) five-sixths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$18 multiplied by the total number of recipients of aid to families with dependent children for such month (which total number, for purposes of this subsection, means (i) the number of individuals with respect to whom such aid in the form of money payments is paid for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to families with dependent children in the form of medical or any other type of remedial care, plus (iii) the number of individuals, not counted under clause (i) or (ii), with respect to whom payments described in section 406(b)(2) are made in such month and included as expenditures for purposes of this paragraph or paragraph (2)); plus

(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (i) the product of \$32 multiplied by the total number of recipients of aid to families with dependent children (other than such aid in the form of foster care) for such month, plus (ii) the product of \$100 multiplied by the total number of recipients of aid to families with dependent children in the form of foster care for such month; and

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof) not counting so much of any expenditure with respect to any month as exceeds \$18 multiplied by the total number of recipients of such aid for such month; and

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision.]

(B) 90 per centum of so much of the sums expended during such quarter as are attributable to the planning, design, development, or installation of such statewide mechanized claims processing and information retrieval systems as (i) meet the conditions of section 402(a) (30), and (ii) the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of State plans approved under title XIX, and State programs with respect to which there is Federal financial participation under title XX, and

(C) one-half of the remainder of such expenditures, except at no payment shall be made with respect to amounts expended in connection with the provision of any service described in section 2002(a) [(1)] of this Act other than services the provision of which is required by section 402(a) (19) to be included in the plan of the State, *or which is a service provided in connection with a community work experience program or work supplementation program under section 409 or 414; and*

(4) [Repealed].

(5) in the case of any State, an amount equal to 50 per centum of the total amount expended under the State plan during such quarter as emergency assistance to needy families with children.

[The number of individuals with respect to whom payments described in section 406(b) (2) are made for any month, who may be included as recipients of aid to families with dependent children for purposes of paragraph (1) or (2), may not exceed 20 per centum of the number of other recipients of aid to families with dependent children for such month. In computing such 20 percent, there shall not be taken into account individuals with respect to whom such payments are made for any month in accordance with section 402(a) (19) (F) or section 402(a) (26).]

In the case of calendar quarters beginning after September 30, 1977, and prior to April 1, 1978, the amount to be paid to each State (as determined under the preceding provisions of this subsection or section 1118, as the case may be) shall be increased in accordance with the provisions of subsection (i) of this section. *No payment shall be made under this subsection with respect to amounts paid to supplement or otherwise increase the amount of aid to families with dependent children found payable in accordance with section 402(a) (13) if such amount is determined to have been paid by the State in recognition of the current or anticipated needs of a family (other than with respect to the first or first and second months of eligibility).*

* * * * *

Definitions

Sec. 406. When used in this part—

(a) The term “dependent child” means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother,

grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece in a place of residence maintained by one or more of such relatives as his or their own home, and

【(2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment, or (C) at the option of the State, under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school in grade twelve or below or regularly attending a course of vocational or technical training, other than a course provided by or through a college or university, designed to fit him for gainful employment;】 *(2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of nineteen and a full-time student in a secondary school (or in the equivalent level of vocational or technical training), if, before he attains age nineteen, he may reasonably be expected to complete the program of such secondary school (or such training);*

(b) The term "aid to families with dependent children" means money payments with respect to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, a dependent child or dependent children, *or, at the option of the State, a pregnant woman but only if it has been medically verified that the child is expected to be born in the month such payments are made or within the three-month period following such month of payment, and who, if such child had been born and was living with her in the month of payment, would be eligible for aid to families with dependent children* and includes (1) money payments or medical care or any type of remedial care recognized under State law to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 407), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 402(a)(7)) which do not meet the preceding requirements of this subsection but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such

child, relative, or other individual, but only with respect to a State whose State plan approval under section 402 includes provision for—

(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2) ;

(B) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family ;

(C) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary ; *and*

[(D) aid in the form of foster home care in behalf of children described in section 408 (a) ; and]

[(E)] (D) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

Payments with respect to a dependent child which are intended to enable the recipient to pay for specific goods, services, or items recognized by the State agency as a part of the child's need under the State plan may (in the discretion of the State or local agency administering the plan in the political subdivision) be made, pursuant to a determination referred to in clause (2) (A), in the form of checks drawn jointly to the order of the recipient and the person furnishing such goods, services, or items and negotiable only upon endorsement by both such recipient and such person ; and payments so made shall be considered for all of the purposes of this part to be payments described in clause (2). Whenever payment with respect to a dependent child are made in the manner described in clause (2) (including payments described in the preceding sentence), a statement of the specific reasons for making such payments in that manner (on which the determination under clause (2) (A) was based) shall be placed in the file maintained with respect to such child by the State or local agency administering the State plan in the political subdivision. *Payments of the type described in clause (2) shall not be subject to the requirements of clause (A) through (E) of such clause (2), when they are made in the manner described in clause (2) at the request of the family member to whom payment would otherwise be made in an unrestricted manner.*

* * * * *

(g) (1) *Notwithstanding the provisions of subsection (b), the term "aid to families with dependent children" does not mean any—*

(A) *amount paid to meet the needs of an unborn child; or*
 (B) *amount paid (or by which a payment is increased) to meet the needs of a woman occasioned by or resulting from her pregnancy, unless, as has been medically verified, the woman's child is expected to be born in the month such payments are made (or increased) or within the three-month period following such month of payment.*

(2) *Notwithstanding paragraph (1), a State may provide that for purposes of title XIX a pregnant woman shall be deemed to be a recipient of aid to families with dependent children under this part if she would be eligible for such aid if such child had been born and was living with her in the month of payment, and such pregnancy has been medically verified.*

Dependent Children of Unemployed [Fathers] Parents

Sec. 407. (a) The term "dependent child" shall, notwithstanding section 406(a), include a needy child who meets the requirements of section 406(a)(2), who has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of **[his father]** *the parent who is the principal earner*, and who is living with any of the relatives specified in section 406(a)(1) in a place of residence maintained by one or more of such relatives as his (or their) own home.

(b) The provisions of subsection (a) shall be applicable to a State if the State's plan approved under section 402—

(1) requires the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

(A) **[such child's father]** *whichever of such child's parents is the principal earner* has not been employed (as determined in accordance with the standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(B) such **[father]** *parent* has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

(C)(i) such father has 6 or more quarters of work (as defined in subsection (d)(1)) in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) he received unemployment compensation under an unemployment compensation law of a State or of the United States, or he was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

(2) provides—

(A) for such assurances as will satisfy the Secretary that **[fathers]** *unemployed parents* of dependent children as defined in subsection (a) will be certified to the Secretary of Labor as provided in section 402(a)(19) within thirty days after receipt of aid with respect to such children;

(B) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained;

(C) for the denial of aid to families with dependent children to any child or relative specified in subsection (a)—

(i) if and for so long as such child's **[father]**, *parent described in paragraph (1) (A)* unless exempt under section 402(a) (19) (A), is *currently* registered pursuant to such section for the work incentive program established under part C of this title, or, if he is exempt under such section by reason of clause (iii) thereof or no such program in which he can effectively participate has been established or provided under section 432(a), is not registered with the public employment offices in the State, and

(ii) with respect to any week for which such child's **[father]** *parent described in paragraph (1) (A)* qualifies for unemployment compensation under an unemployment compensation law of a State or of the United States, but refuses to apply for or accept such unemployment compensation; and

(D) for the reduction of the aid of families with dependent children otherwise payable to any child or relative specified in subsection (a) by the amount of any unemployment compensation that such child's **[father]** *parent described in paragraph (1) (A)* receives under an unemployment compensation law of a State or of the United States.

(c) Notwithstanding any other provisions of this section, expenditures pursuant to this section shall be excluded from aid to families with dependent children (A) where such expenditures are made under the plan with respect to any dependent child as defined in subsection (a), (i) for any part of the 30-day period referred to in subparagraph (A) of subsection (b) (1), or (ii) for any period prior to the time when the **[father]** *parent* satisfies subparagraph (B) of such subsection, and (B) if, and for as long as, no action is taken (after the 30-day period referred to in paragraph (A) of subsection (b) (2)), under the program therein specified, to certify such **[father]** *parent* to the Secretary of Labor pursuant to section 402(a) (19).

(d) For purposes of this section—

(1) the term "quarter of work" with respect to any individual means a calendar quarter in which such individual received earned income of not less than \$50 (or which is a "quarter of coverage" as defined in section 213(a) (2)), or in which such individual participated in a community work and training program under section 409 or any other work and training program subject to the limitations in section 409, or the work incentive program established under part C;

(2) the term "calendar quarter" means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31; [and]

(3) an individual shall, for purposes of section 407(b)(1)(C), be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

(A) he would have been eligible to receive such unemployment compensation upon filing application, or

(B) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application[.]

(4) the phrase "whichever of such child's parents is the principal earner", in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.

(e) The Secretary of Health, Education, and Welfare and the Secretary of Labor shall jointly enter into an agreement with each State which is able and willing to do so for the purpose of (1) simplifying the procedures to be followed by unemployed [fathers] parents and other unemployed persons in such State in registering pursuant to section 402(a)(19) for the work incentive program established by part C of this title and in registering with public employment offices (under this section and otherwise) or in connection with applications for unemployment compensation, by reducing the number of locations or agencies where such persons must go in order to register for such programs and in connection with such applications, and (2) providing where possible for a single registration satisfying this section and the requirements of both the work incentive program and the applicable unemployment compensation laws.

[Federal Payments for Foster Home Care of Dependent Children

[Sec. 408. Effective for the period beginning May 1, 1961—

[(a) the term "dependent child" shall, notwithstanding section 406(a), also include a child (1) who would meet the requirements of such section 406(a) or of section 407, except for his removal after April 30, 1961, from the home of a relative (specified in such section 406(a)) pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian, or as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child, (2) whose placement and care are the responsibility of (A) the State or local agency administering the State plan approved under section 402, or (B) any other public agency with whom the State agency administering or supervising the administration of such State

plan has made an agreement which is still in effect and which includes provision for assuring development of a plan, satisfactory to such State agency, for such child as provided in paragraph (f) (1) and such other provisions as may be necessary to assure accomplishment of the objectives of the State plan approved under section 402, (3) who has been placed in a foster home or child-care institution as a result of such voluntary placement agreement or judicial determination, and (4) who (A) received aid under such State plan in or for the month in which such agreement was entered into or court proceedings leading to such determination were initiated, or (B) (i) would have received such aid in or for such month if application had been made therefor, or (ii) in the case of a child who had been living with a relative specified in section 406(a) within six months prior to the month in which such agreement was entered into or such proceedings were initiated, would have received such aid in or for such month if in such month he had been living with (and removed from the home of) such a relative and application had been made therefor;

[(b) the term "aid to families with dependent children" shall, notwithstanding section 406(b), include also foster care in behalf of a child described in paragraph (a) of this section—

[(1) in the foster family home of any individual, whether the payment therefor is made to such individual or to a public or nonprofit private child-placement or child-care agency, or

[(2) in a child-care institution, whether the payment therefor is made to such institution or to a public or nonprofit private child-placement or child-care agency, but subject to limitations prescribed by the Secretary with a view to including as "aid to families with dependent children" in the case of such foster care in such institutions only those items which are included in such term in the case of foster care in the foster family home of an individual;

[(c) the number of individuals counted under clause (A) of section 403(a) (1) for any month shall include individuals (not otherwise included under such clause) with respect to whom expenditures were made in such month as aid to families with dependent children in the form of foster care; and

[(d) services described in paragraph (f) (2) of this section shall be considered as part of the administration of the State plan for purposes of section 403(a) (3); but only with respect to a State whose State plan approved under section 402—

[(e) includes aid for any child described in paragraph (a) of this section, and

[(f) includes provision for (1) development of a plan for each such child (including periodic review of the necessity for the child's being in a foster family home or child-care institution) to assure that he receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed or to otherwise make possible his being placed in the home of a relative specified in section 406(a), and

(2) use by the State or local agency administering the State plan, to the maximum extent practicable, in placing such a child in a foster family home or child-care institution, of the services of employees, of the State public-welfare agency referred to in section 522(a) (relating to allotments to States for any child welfare services under part 3 of title V) or any local agency participating in the administration of the plan referred to in such section, who perform functions in the administration of such plan.

【For the purposes of this section, the term “foster family home” means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and the term “child-care institution” means a nonprofit private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing; but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

【For the purposes of this section, the provisions of subsections (d), (e), (f), and (g) of section 472 shall apply.】

【Community Work and Training Programs

【Sec. 409. (a) For the purpose of assisting the States in encouraging, through community work and training programs of a constructive nature, the conservation of work skills and the development of new skills for individuals who have attained the age of 18 and are receiving aid to families with dependent children, under conditions which are designed to assure protection of the health and welfare of such individuals and the dependent children involved, expenditures (other than for medical or any other type of remedial care) for any month with respect to a dependent child (including payments to meet the needs of any relative or relatives, specified in section 406(a), with whom he is living) under a State plan approved under section 402 shall not be excluded from aid to families with dependent children because such expenditures are made in the form of payments for work performed in such month by any one or more of the relatives with whom such child is living if such work is performed for the State agency or any other public agency under a program (which need not be in effect in all political subdivisions of the State) administered by or under the supervision of such State agency, if there is State financial participation in such expenditures, and if such State plan includes—

【(1) provisions which, in the judgment of the Secretary, provide reasonable assurance that—

【(A) appropriate standards for health, safety, and other conditions applicable to the performance of such work by such relatives are established and maintained;

[(B) payments for such work are at rates not less than the minimum rate (if any) provided by or under State law for the same type of work and not less than the rates prevailing on similar work in the community;

[(C) such work is performed on projects which serve a useful public purpose, do not result either in displacement of regular workers or in the performance by such relatives of work that would otherwise be performed by employees of public or private agencies, institutions, or organizations, and (except in cases of projects which involve emergencies or which are generally of a nonrecurring nature) are of a type which has not normally been undertaken in the past by the State or community, as the case may be;

[(D) in determining the needs of any such relative, any additional expenses reasonably attributable to such work will be considered;

[(E) any such relative shall have reasonable opportunities to seek regular employment and to secure any appropriate training or retraining which may be available;

[(F) any such relative will, with respect to the work so performed, be covered under the State workmen's compensation law or be provided comparable protection; and

[(G) aid under the plan will not be denied with respect to any such relative (or the dependent child) for refusal by such relative to perform any such work if he has good cause for such refusal;

[(2) provision for entering into cooperative arrangements with the system of public employment offices in the State looking toward employment or occupational training of any such relatives performing work under such program, including appropriate provision for registration and periodic reregistration of such relatives and for maximum utilization of the job placement services and other services and facilities of such offices;

[(3) provision for entering into cooperative arrangements with the State agency or agencies responsible for administering or supervising the administration of vocational education and adult education in the State, looking toward maximum utilization of available public vocational or adult education services and facilities in the State in order to encourage the training or retraining of any such relatives performing work under such program and otherwise assist them in preparing for regular employment;

[(4) provision for assuring appropriate arrangements for the care and protection of the child during the absence from the home of any such relative performing work under such program in order to assure that such absence and work will not be inimical to the welfare of the child;

[(5) provision that there be no adjustment or recovery by the State or any political subdivision thereof on account of any payments which are correctly made for such work; and

[(6) such other provisions as the Secretary finds necessary to assure that the operation of such program will not interfere with achievement of the objectives set forth in section 401.

[(b) In the case of any State which makes expenditures in the form described in subsection (a) under its State plan approved under section 402, the proper and efficient administration of the State plan, for purposes of section 403(a) (3) and (4), may not include the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in subsection (a) or the cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.]

Community Work Experience Programs

Sec. 409. (a) (1) *Any State which chooses to do so may establish a community work experience program in accordance with this section. The purpose of the community work experience program is to provide experience and training for individuals not otherwise able to obtain employment, in order to assist them to move into regular employment. Community work experience programs shall be designed to improve the employability of participants through actual work experience and training and to enable individuals employed under community work experience programs to move promptly into regular public or private employment. The facilities of the State public employment offices may be utilized to find employment opportunities for recipients under this program. Community work experience programs shall be limited to projects which serve a useful public purpose in fields such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, and day care. To the extent possible, the prior training, experience, and skills of a recipient shall be utilized in making appropriate work experience assignments. A community work experience program established under this section shall provide—*

(A) *appropriate standards for health, safety, and other conditions applicable to the performance of work;*

(B) *that the program does not result in displacement of persons currently employed, or the filling of established unfilled position vacancies;*

(C) *reasonable conditions of work, taking into account the geographic region, the residence of the participants, and the proficiency of the participants;*

(D) *that participants will not be required, without their consent, to travel an unreasonable distance from their homes or remain away from their homes overnight;*

(E) *that the maximum number of hours in any month that a participant may be required to work is that number which equals the amount of aid payable with respect to the family of which such individual is a member under the State plan approved under this part, divided by the greater of the Federal or the applicable State minimum wage; and*

(F) *that provision will be made for transportation and other costs, not in excess of an amount established by the Secretary, reasonably necessary and directly related to participation in the program.*

The Secretary shall prescribe rules for determining, in cases to which subparagraph (E) applies and in which the members of the household receiving a food stamp allotment are not all members of the family with respect to which aid under this part is payable, the portion of a household's food stamp allotment that, for purposes of subparagraph (E), may be considered to be the food stamp allotment provided to the family.

(2) Nothing contained in this section shall be construed as authorizing the payment of aid under this part as compensation for work performed, nor shall a participant be entitled to a salary or to any other work or training expense provided under any other provision of law by reason of his participation in a program under this section.

(3) Nothing in this part or part C, or in any State plan approved under this part, shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate, whether or not such terms, conditions, and cases and consistent with section 402(a) (19) or part C) a community work experience program in accordance with this section.

(b) (1) Each recipient of aid under the plan who is registered under section 402(a) (19) shall participate, upon referral by the State agency, in a community work experience program unless such recipient is currently employed for no fewer than 80 hours a month and is earning an amount not less than the applicable minimum wage for such employment.

(2) In addition to an individual described in paragraph (1), the State agency may also refer, for participation in programs under this section, an individual who would be required to register under section 402(a) (19) (A) but for the exception contained in clause (v) of such section (but only if the child for whom the parent or relative is caring is not under the age of three and child care is available for such child), or in clause (iii) of such section.

(3) The chief executive officer of the State shall provide coordination between a community work experience program operated pursuant to this section and the work incentive program operated pursuant to part C so as to insure that job placement will have priority over participation in the community work experience program, and that individuals eligible to participate in both such programs are not denied aid under the State plan on the grounds of failure to participate in one such program if they are actively and satisfactorily participating in the other. The chief executive officer of the State may provide that part-time participation in both such programs may be required where appropriate.

(c) The provisions of section 402(a) (19) (F) shall apply to any individual referred to a community work experience program who fails to participate in such program in the same manner as they apply to an individual to whom section 402(a) (19) applies.

(d) In the case of any State which makes expenditures in the form described in subsection (a) under its State plan approved under section 402, expenditures for the proper and efficient administration of the State plan, for purposes of section 403(a) (3), may not include the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in subsection (a) or the

cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.

* * * * *

Prorating of Shelter Allowance in Certain Cases Where Child Lives With Relative Not Legally Responsible for His Support

Sec. 412. (a) * * *

(b) For purposes of subsection (a), the term "closely related family members" of a child means those relatives of his who are specified in section 406(a)(1) and any other individual for whose support such a relative is legally responsible, but does not include [any such relative] *a stepparent whose income is taken into consideration under section 402(a)(31) (regardless of whether such income exceeds the sum specified in such section) or any other such relative* or other individual (1) with respect to whom benefits are provided under another public program eligibility for which is based on need, or (2) whose presence in the home would not increase the total amount which would be allowed for shelter, utilities, and similar expenses if he was eligible for aid.

* * * * *

Work Supplementation Program

Sec. 414. (a) *It is the purpose of this section to allow a State to institute a work supplementation program under which such State, to the extent such State determines to be appropriate, may make jobs available, on a voluntary basis, as an alternative to aid otherwise provided under the State plan approved under this part.*

(b) (1) *Notwithstanding the provisions of section 406 or any other provision of law, Federal funds may be paid to a State under this part, subject to the provisions of this section, with respect to expenditures incurred in operating a work supplementation program under this section.*

(2) *Nothing in this part or part C, or in any State plan approved under this part, shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate, whether or not such terms, conditions, and cases are consistent with section 402(a)(19) or part C) a work supplementation program in accordance with this section.*

(3) *Notwithstanding section 402(a)(23) or any other provision of law, a State may adjust the levels of the standards of need under the State plan as the State determines to be necessary and appropriate for carrying out a work supplementation program under this section.*

(4) *Notwithstanding section 402(a)(1) or any other provision of law, a State operating a work supplementation program under this section may provide that the needs standards in effect in those areas of the State in which such program is in operation may be different from the needs standards in effect in the areas in which such program is not in operation, and such State may provide that the needs standards for categories of recipients of aid may vary among such categories as the*

State determines to be appropriate on the basis of ability to participate in the work supplementation program.

(5) Notwithstanding any other provision of law, a State may make further adjustments in the amounts of aid paid under the plan to different categories or recipients (as determined under paragraph (4)) in order to offset increases in benefits from needs related programs (other than the State plan approved under this part) as the State determines to be necessary and appropriate to further the purposes of the work supplementation program.

(6) Notwithstanding section 402(a)(8) or any other provision of law, a State operating a work supplementation program under this section may reduce or eliminate the amount of earned income to be disregarded under the State plan as the State determines to be necessary and appropriate to further the purposes of the work supplementation program.

(c) (1) A work supplementation program operated by a State under this section shall provide that any individual who is an eligible individual (as determined under paragraph (2)) may choose to take a supplemented job (as defined in paragraph (3)) to the extent supplemented jobs are available under the program. Payments by the State to individuals or to employers under the program shall be expenditures incurred by the State for aid to families with dependent children, except as limited by subsection (d).

(2) For purposes of this section, an eligible individual is an individual who is in a category which the State determines shall be eligible to participate in the work supplementation program, and who would, at the time of his placement in such job, be eligible for assistance under the State plan if such State did not have a work supplementation program in effect and had not altered its State plan accordingly, as such State plan was in effect in May 1981, or as modified thereafter as required by Federal law.

(3) For purposes of this section, a supplemented job is—

(A) a job position provided to an eligible individual by the State or local agency administering the State plan under this part;

(B) a job position provided to an eligible individual by a public or nonprofit entity for which all or part of the wages are paid by such State or local agency; or

(C) a job position provided to an eligible individual by a proprietary entity involving the provision of child day care services for which all or part of the wages are paid by such State or local agency, but only if such entity does not claim a credit for any part of the wages paid to such eligible individual under section 40 of the Internal Revenue Code of 1954 (relating to credit for expenses of the work incentive program) or section 44B of such Code (relating to credit for employment of certain new employees).

A State may provide or subsidize any job position under the program as such State determines to be appropriate, but acceptance of any such position shall be voluntary.

(d) The amount of the Federal payment to a State under section 403 for any quarter for expenditures incurred in operating a work supplementation program shall not exceed an amount equal to the difference between—

(1) the amount which would have been paid under section 403 to such State for such quarter under the State plan if it did not have a work supplementation program in effect and had not altered its State plan accordingly, as such State plan was in effect in May 1981, or as modified thereafter as required by Federal law; and

(2) the amount paid to such State under section 403 for such quarter exclusive of the amount so paid for such quarter for the work supplementation program.

(e) (1) Nothing in this section shall be construed as requiring a State or local agency administering the State plan to provide employee status to any eligible individual to whom it provides a job position under the work supplementation program, or with respect to whom it provides all or part of the wages paid to such individual by another entity under such program.

(2) Nothing in this section shall be construed as requiring such State or local agency to provide that eligible individuals filling job positions provided by other entities under such program be provided employee status by such entity during the first 13 weeks during which they fill such position.

(3) Wages paid under a work supplementation program shall be considered to be earned income for purposes of any provision of law.

(f) Any work supplementation program operated by a State shall be administered by—

(1) the agency designated to administer or supervise the administration of the State plan under section 402(a)(3); or

(2) the agency (if any) designated to administer the community work experience program under section 409.

(g) Any State which chooses to operate a work supplementation program under this section may choose to provide that any individual who participates in such program, and any child or relative of such individual (or other individual living in the same household as such individual) who would be eligible for aid under the State plan approved under this part if such State did not have a work supplementation program, shall be considered individuals receiving aid under the State plan approved under this part for purposes of eligibility for medical assistance under the State plan approved under title XIX.

(h) No individual receiving a grant under the State plan shall be excused, by reason of the fact that such State has a work supplementation program, from any requirement of this part of part C relating to work requirements.

[Part B—Child-Welfare Services

[Appropriation

[Sec. 420. (a) For the purpose of enabling the United States, through the Secretary, to cooperate with State public welfare agencies, in establishing, extending, and strengthening child welfare services, there is authorized to be appropriated for each fiscal year the sum of \$266,000,000.

[(b) Funds appropriated for any fiscal year pursuant to the authorization contained in subsection (a) shall be included in the appropriation Act (or supplemental appropriation Act) for the fiscal year

preceding the fiscal year for which such funds are available for obligation. In order to effect a transition to this method of timing appropriation action, the preceding sentence shall apply notwithstanding the fact that its initial application will result in the enactment in the same year (whether in the same appropriation Act or otherwise) of two separate appropriations, one for the then current fiscal year and one for the succeeding fiscal year.

[Allotments to States

[Sec. 421. (a) The sum appropriated pursuant to section 420 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary as follows: He shall first allot \$70,000 to each State, and shall then allot to each State an amount which bears the same ratio to the remainder of such sum as the product of (1) the population of the State under the age of twenty-one and (2) the allotment percentage of the State (as determined under this section) bears to the sum of the corresponding products of all the States.

[(b) The "allotment percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 per centum or more than 70 per centum, and (2) the allotment percentage shall be 70 per centum in the case of Puerto Rico, the Virgin Islands, and Guam.

[(c) The allotment percentage for each State shall be promulgated by the Secretary between October 1 and November 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning October 1 next succeeding such promulgation.

[(d) For purposes of this section, the term "United States" means the fifty States and the District of Columbia.

[State Plans for Child Welfare Services

[Sec. 422. (a) In order to be eligible for payment under this part, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b) (1), and which meets the requirements of subsection (b).

[(b) Each plan for child welfare services under this part shall—

[(1) provide that (A) the individual or agency designated pursuant to section 2003(d) (1) (C) to administer or supervise the administration of the State's services program will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980), and (B) to the extent that child welfare

services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;

[(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under title XX, under the State plan approved under part A of this title, under the State plan approved under part E of this title, and under other State programs having a relationship to the program under this part, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

[(3) provide that the standards and requirements imposed with respect to child day care under title XX shall apply with respect to day care services under this part, except insofar as eligibility for such services is involved;

[(4) provide for the training and effective use of paid paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan, and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency;

[(5) contain a description of the services to be provided and specify the geographic areas where such services will be available;

[(6) contain a description of the steps which the State will take to provide child welfare services and to make progress in—

[(A) covering additional political subdivisions,

[(B) reaching additional children in need of services, and

[(C) expanding and strengthening the range of existing

services and developing new types of services,

along with a description of the State's child welfare services staff development and training plans;

[(7) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies in accordance with State and local programs and arrangements, as authorized by the State; and

[(8) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require.

[Payment to States

[Sec. 423. (a) From the sums appropriated therefor and the allotment under this part, subject to the conditions set forth in this section and in section 427, the Secretary shall from time to time pay to each State that has a plan developed in accordance with section 422 an amount equal to 75 per centum of the total sum expended under the plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child welfare services.

[(b) The method of computing and making payments under this section shall be as follows:

[(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of this section.

[(2) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

[(c) (1) No payment may be made to a State under this part, for any fiscal year beginning after September 30, 1979, with respect to State expenditures made for (A) child day care necessary solely because of the employment, or training to prepare for employment, of a parent or other relative with whom the child involved is living, (B) foster care maintenance payments, and (C) adoption assistance payments, to the extent that the Federal payment with respect to those expenditures would exceed the total amount of the Federal payment under this part for fiscal year 1979.

[(2) Expenditures made by a State for any fiscal year which begins after September 30, 1979, for foster care maintenance payments shall be treated for purposes of making Federal payments under this part with respect to expenditures for child welfare services, as if such foster care maintenance payments constituted child welfare services of a type to which the limitation imposed by paragraph (1) does not apply; except that the amount payable to the State with respect to expenditures made for other child welfare services and for foster care maintenance payments during any such year shall not exceed 100 per centum of the amount of the expenditures made for child welfare services for which payment may be made under the limitation imposed by paragraph (1) as in effect without regard to this paragraph.

[(d) No payment may be made to a State under this part in excess of the payment made under this part for fiscal year 1979, for any fiscal year beginning after September 30, 1979, if the latter fiscal year the total of the State's expenditures for child welfare services under this part (excluding expenditures for activities) specified in subsection (c) (1) is less than the total of the State's expenditures under this part (excluding expenditures for such activities) for fiscal year 1979.

[Reallotment

[Sec. 424. The amount of any allotment to a State under section 421 for any fiscal year which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in section 422 shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out their State plans so developed for sums in excess of those previously allotted to them under section 421 and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the State plans so developed, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one.

and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under section 421.

[Definitions]

[Sec. 425. (a) (1) For purposes of this title, the term "child welfare services" means public social services which are directed toward the accomplishment of the following purposes: (A) protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (B) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (D) restoring to their families children who have been removed, by the provision of services to the child and the families; (E) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (F) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

[(2) Funds expended by a State for any calendar quarter to comply with the statistical report required by section 476(b), and funds expended with respect to nonrecurring costs of adoption proceedings in the case of children placed for adoption with respect to whom assistance is provided under a State plan for adoption assistance approved under part E of this title, shall be deemed to have been expended for child welfare services.

[(b) For other definitions relating to this part and to part E of this title, see section 475 of this Act.

[Research, Training, or Demonstration Projects]

[Sec. 426. (a) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine—

[(1) for grants by the Secretary—

[(A) to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child-welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare;

[(B) to State or local public agencies responsible for administering, or supervising the administration of, the plan under this part, for projects for the demonstration of the utilization of research (including findings resulting therefrom) in the field of child welfare in order to encourage experimental and special types of welfare services; and

[(C) to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships with such stipends and allowances as may be permitted by the Secretary; and

[(2) for contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research, special projects, or demonstration projects relating to such matters.

[(b) Payments of grants or under contracts or cooperative arrangements under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants, contracts, or other arrangements.

[Foster Care Protection Required for Additional Federal Payments

[Sec. 427. (a) If, for any fiscal year after fiscal year 1979, there is appropriated under section 420 a sum in excess of \$141,000,000, a State shall not be eligible for payment from its allotment in an amount greater than the amount for which it would be eligible if such appropriation were equal to \$141,000,000, unless such State—

[(1) has conducted an inventory of all children who have been in foster care under the responsibility of the State for a period of six months preceding the inventory, and determined the appropriateness of, and necessity for, the current foster placement, whether the child can be or should be returned to his parents or should be freed for adoption, and the services necessary to facilitate either the return of the child or the placement of the child for adoption or legal guardianship; and

[(2) has implemented and is operating to the satisfaction of the Secretary—

[(A) a statewide information system from which the status, demographic characteristics, location, and goals for the placement of every child in foster care or who has been in such care within the preceding twelve months can readily be determined;

[(B) a case review system (as defined in section 475(5)) for each child receiving foster care under the supervision of the State; and

[(C) a service program designed to help children, where appropriate, return to families from which they have been removed or be placed for adoption or legal guardianship.

[(b) if for each of any two consecutive fiscal years after the fiscal year 1979, there is appropriated under section 420 a sum equal to \$266,000,000, each State's allotment amount for any fiscal year after such two consecutive fiscal years shall be reduced to an amount equal to its allotment amount for the fiscal year 1979, unless such State—

[(1) has completed an inventory of the type specified in subsection (a) (1);

[(2) has implemented and is operating the program and systems specified in subsection (a) (2) ; and

[(3) has implemented a preplacement preventive service program designed to help children remain with their families.

[(c) Any amounts expended by a State for the purpose of complying with the requirements of subsection (a) or (b) shall be conclusively presumed to have been expended for child welfare services.

[Payments to Indian Tribal Organizations

[Sec. 428. (a) The Secretary may, in appropriate cases (as determined by the Secretary) make payments under this part directly to an Indian tribal organization within any State which has a plan for child welfare services approved under this part. Such payments shall be made in such manner and in such amounts as the Secretary determines to be appropriate.

[(b) Amounts paid under subsection (a) shall be deemed to be a part of the allotment (as determined under section 421) for the State in which such Indian tribal organization is located.

[(c) For purposes of this section—

[(1) the term “tribal organization” means the recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body; and

[(2) the term “Indian tribe means any tribe, band, nation, or other organized group or community of Indians (including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (Public 92-203: 85 Stat. 688)) which (A) is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, or (B) is located on, or in proximity to, a Federal or State reservation or rancheria.]

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Part C—Work Incentive Program for Recipients of Aid Under State Plan Approved Under Part A

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Work Incentive Demonstration Program

Sec. 445 (a) *Notwithstanding any other provision of this part and part A of this title, any State may elect as an alternative to the work incentive program otherwise provided in this part, and subject to the provisions of this section, to operate a work incentive demonstration program for the purpose of demonstrating single agency administration of the work-related objectives of this Act, and to receive payments under the provisions of this section.*

(b) (1) *Not later than sixty days following the date of the enactment of this section, the Governor of a State which desires to operate a work incentive demonstration program under this section shall submit to the Secretary of Health and Human Services a letter of appli-*

cation stating such intent. Accompanying the letter of application shall be a State program plan which must—

(A) provide that the agency conducting the demonstration program within the State shall be the single State agency which administers or supervises the administration of the State plan under part A of this title;

(B) provide that all persons eligible for or receiving assistance under the aid to families with dependent children program shall be eligible to participate in, and shall be required to participate in, the work incentive demonstration program, subject to the same criteria for participation in such demonstration program as are in effect under this part and part A during the month before the month in which the demonstration program commences;

(C) provide that the criteria for participation in the work incentive demonstration program shall be uniform throughout the State;

(D) provide a statement of the objectives which the State expects to meet through operation of a work incentive demonstration program, with emphasis on how the State expects to maximize client placement in nonsubsidized private sector employment;

(E) describe the techniques to be used to achieve the objectives of the work incentive demonstration program, which may include but shall not be limited to: maximum periods of participation, job training, job find clubs, grant diversion to either public or private sector employers, services contracts with State employment services, prime sponsors under the Comprehensive Employment and Training Act of 1973, or private placement agencies, targeted jobs tax credit outreach campaigns, and performance-based placement incentives; and

(F) set forth the format and frequency of reporting of information regarding operation of the work incentive demonstration program.

(2) A State's application to participate in the work incentive program shall be deemed approved unless the Secretary of Health and Human Services notifies the State in writing of disapproval within forty-five days of the date of application. The Secretary of Health and Human Services shall set forth the reasons for disapproval and provide an opportunity for resubmission of the plan within forty-five days of the receipt of the notice of disapproval. An application shall not be finally disapproved unless the Secretary of Health and Human Services determines that the State's program plan would be less effective than the requirements set forth in this title, other than this section.

(3) The Secretary of Health and Human Services shall furnish copies of approved plans, statistical reports, and evaluation reports to the Secretary of Labor.

(c) Subject to the statement of objectives and description of techniques to be used in implementing its work incentive demonstration program, as set forth in its program plan, a State shall be free to design a program which best addresses its individual needs, makes best use of its available resources, and recognizes its labor market conditions. Other than criteria for participation in the State's work incentive demonstration project, which shall be uniform throughout the

State, the components of the program may vary by geographic area or by political subdivision.

(d) A State's work incentive demonstration program, if initially approved, shall be in force for a three-year period. During this period, the State may elect to use up to six months for planning purposes. During such planning period, all requirements of part A and this part C shall remain in full force and effect.

(e) The Secretary of Health and Human Services shall conduct two evaluations of a State's work incentive demonstration program. The first evaluation shall be conducted at the conclusion of the first twelve months of operation of the demonstration program. The second evaluation shall be conducted at the conclusion of the demonstration program. Both evaluations shall compare placement rates during the demonstration program with placement rates achieved during a number of previous years, to be determined by the Secretary of Health and Human Services.

(f) (1) For each year of its demonstration program, a State which is operating such program shall be funded in an amount equal to its initial annual 1981 allocation under the work incentive program set forth in this part, plus any other Federal funds which the State may properly receive under any statute for establishing work programs for recipients of aid to families with dependent children.

(2) Such funds shall only be used by the State for administering and operating its work incentive demonstration program. These funds shall not be used for direct grants of assistance under the aid to families with dependent children program.

(g) Earnings derived from participation in a State's work incentive demonstration program shall not result in a determination of financial ineligibility for assistance under the aid to families with dependent children program.

Part D—Child Support and Establishment of Paternity

Appropriation

Sec. 451. For the purpose of enforcing the support obligations owed by absent parents to their children *and the spouse (or former spouse) with whom such children are living*, locating absent parents, establishing paternity, and obtaining child *and spousal* support, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part.

Duties of the Secretary

Sec. 452. (a) The Secretary shall establish, within the Department of Health, Education, and Welfare a separate organizational unit, under the direction of a designee of the Secretary, who shall report directly to the Secretary and who shall—

(1) establish such standards for State programs for locating absent parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) receiving aid to families with dependent children on behalf of an absent parent's

child as he determines to be necessary to assure that such programs will be effective;

(2) establish minimum organizational and staffing requirements for State units engaged in carrying out such programs under plans approved under this part;

(3) review and approve State plans for such programs;

(4) evaluate the implementation of State programs established pursuant to such plan, conduct such audits of State programs established under the plan approved under this part as may be necessary to assure their conformity with the requirements of this part, and, not less often than annually, conduct a complete audit of the programs established under such plan in each State and determine for the purposes of the penalty provision of section 403(h) whether the actual operation of such programs in each State conforms to the requirements of this part;

(5) assist States in establishing adequate reporting procedures and maintain records of the operations of programs established pursuant to this part in each State;

(6) maintain records of all amounts collected and disbursed under programs established pursuant to the provisions of this part and of the costs incurred in collecting such amounts;

(7) provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity;

(8) receive applications from States for permission to utilize the courts of the United States to enforce court orders for support against absent parents and, upon a finding that (A) another State has not undertaken to enforce the court order of the originating State against the absent parent within a reasonable time, and (B) that utilization of the Federal courts is the only reasonable method of enforcing such order, approve such applications;

(9) operate the Parent Locator Service established by section 453; and

(10) not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the provisions of this part, which report shall include, but not be limited to, the following:

(A) total program costs and collections set forth in sufficient detail to show the cost to the States and the Federal Government, the distribution of collections to families, State and local governmental units, and the Federal Government; and an identification of the financial impact of the provisions of this part;

(B) costs and staff associated with the Office of Child Support Enforcement;

(C) the number of child support cases (*with separate identification of the number in which collection of spousal support was involved*) in each State during each quarter of the fiscal year last ending before the report is submitted and during each quarter of the preceding fiscal year (including the transitional period beginning July 1, 1976, and ending

September 30, 1976, in the case of the first report to which this subparagraph applies), and the disposition of such cases;

(D) the status of all State plans under this part as of the end of the fiscal year last ending before the report is submitted, together with an explanation of any problems which are delaying or preventing approval of State plans under this part;

(E) data, by State, on the use of the Federal Parent Locator Service, and the number of locate requests submitted without the absent parent's social security account number;

(F) the number of cases, by State, in which an applicant for or recipient of aid under a State plan approved under part A has refused to cooperate in identifying and locating the absent parent and the number of cases in which refusal so to cooperate is based on good cause (as determined in accordance with the standards referred to in section 402(a)(26)(B)(ii));

(G) data, by State, on the use of Federal courts and on use of the Internal Revenue Service for collections, the number of court orders on which collections were made, the number of paternity determinations made and the number of parents located, in sufficient detail to show the cost and benefits to the States and to the Federal Government; and

(H) the major problems encountered which have delayed or prevented implementation of the provisions of this part during the fiscal year last ending prior to the submission of such report.

The information contained in any such report under subparagraph (A) shall specifically include (i) the total amount of child support payments collected as a result of services furnished during the fiscal year involved to individuals under section 454(6), (ii) the cost to the States and to the Federal Government of furnishing such services to those individuals, and (iii) the extent to which the furnishing of such services were successful in providing sufficient support to those individuals to assure that they did not require assistance under the State plan approved under part A.

(b) The Secretary shall, upon the request of any State having in effect a State plan approved under this part, certify the amount of any child support obligation assigned to such State, *including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A* (or undertaken to be collected by such State pursuant to section 454(6)) to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954. No amount may be certified for collection under this subsection except the amount of the delinquency under a court *or administrative* order for support and upon a showing by the State that such State has made diligent and reasonable efforts to collect such amounts utilizing its own collection mechanisms, and upon an agreement that the State will reimburse the United States for any costs involved in making the collection. The Secretary after consultation with the Secretary of the Treasury may, by regulation, establish criteria for accepting amounts for col-

lection and for making certification under this subsection including imposing such limitations on the frequency of making such certifications under this subsection.

Parent Locator Service

Sec. 453. (a) * * *

(c) As used in subsection (a), the term "authorized person" means—

(1) any agent or attorney of any State having in effect a plan approved under this part, who has the duty or authority under such plans to seek to recover any amounts owed as child support *or support for a spouse receiving aid to families with dependent children* (including, when authorized under the State plan, any official of a political subdivision);

(2) the court which has authority to issue an order against an absent parent for the support and maintenance of a child, or any agent of such court; and

(3) the resident parent, legal guardian, attorney, or agent of a child (other than a child receiving aid under part A of this title) (as determined by regulations prescribed by the Secretary) without regard to the existence of a court order against an absent parent who has a duty to support and maintain any such child.

* * * * *

State Plan for Child and Spousal Support

Sec. 454. A State plan for child and spousal support must—

(1) provide that it shall be in effect in all political subdivisions of the State;

(2) provide for financial participation by the State;

(3) provide for the establishment or designation of a single and separate organizational unit, which meets such staffing and organizational requirements as the Secretary may by regulation prescribe, within the State to administer the plan;

(4) provide that such State will undertake—

(A) in the case of a child born out of wedlock with respect to whom an assignment under section 402(a)(26) of this title is effective, to establish the paternity of such child unless the agency administering the plan of the State under part A of this title determines in accordance with the standards prescribed by the Secretary pursuant to section 402(a)(26)(B) that it is against the best interests of the child to do so, and

(B) in the case of any child with respect to whom such assignment is effective, to secure support for such child from his parent (or from any other person legally liable for such support) [.] and, at the option of the State, from such parent for his spouse (or former spouse) receiving aid to families with dependent children (but only if a support obligation has been established with respect to such spouse), utilizing any reciprocal arrangements adopted with other States (unless the agency administering the plan of the State under part A of this title determines in accordance with the standards prescribed by the Secretary pursuant to section 402(a)

(26) (B) that it is against the best interests of the child to do so), except that when such arrangements and other means have proven ineffective, the State may utilize the Federal courts to obtain or enforce court orders for support;

(5) provide that, in any case in which [child] support payments are collected for a [child] *an individual* with respect to whom an assignment under section 402(a) (26) is effective, such payments shall be made to the State for distribution pursuant to section 457 and shall not be paid directly to the family except that this paragraph shall not apply to such payments (except as provided in section 457(c)) for any month in which the amount collected is sufficient to make such family ineligible for assistance under the State plan approved under part A;

(6) provide that (A) the child support collection or paternity determination services established under the plan shall be made available to any individual not otherwise eligible for such services upon application filed by such individual with the State, (B) an application fee for furnishing [such services] *services under the State plan (other than collection of support)* may be imposed, except that the amount of any such application fee shall be reasonable, as determined under regulations of the Secretary, and [(C) any costs in excess of the fee so imposed may be collected from such individual by deducting such costs from the amount of any recovery made;] (C) *the State will retain, but only if it is the State which makes the collection, the fee imposed under State law as required under paragraph (19);*

(7) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials (A) to assist the agency administering the plan, including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the agency administering the plan;

(8) provide that the agency administering the plan will establish a service to locate absent parents utilizing—

(A) all sources of information and available records, and

(B) the Parent Locator Service in the Department of Health, Education, and Welfare;

(9) provide that the State will, in accordance with standards prescribed by the Secretary, cooperate with any other State—

(A) in establishing paternity, if necessary,

(B) in locating an absent parent residing in the State (whether or not permanently) against whom any action is being taken under a program established under a plan approved under this part in another State,

(C) in securing compliance by an absent parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of [a] *the child or children or the spouse* of such parent with respect to whom aid is being provided under the plan of such other State, and

(D) in carrying out other functions required under a plan approved under this part;

(10) provide that the State will maintain a full record of collections and disbursements made under the plan and have an adequate reporting system;

(11) provide that amounts collected as [child] support shall be distributed as provided in section 457;

(12) provide that any payment required to be made under section 456 or 457 to a family shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children;

(13) provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating absent parents, establishing paternity, obtaining support orders, and collecting support payments;

(14) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe;¹

(15) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary);

(16) provide, at the option of the State, for the establishment, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under section 452(d), of an automatic data processing and information retrieval system designed effectively and efficiently to assist management in the administration of the State plan, in the State and localities thereof, so as (A) to control, account for, and monitor (i) all the factors in the [child] support enforcement collection and paternity determination process under such plan (including, but not limited to, (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes) of any individual with respect to whom [child] support obligations are sought to be established or enforced and with respect to any person to whom such support obligations are owing) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether such individual is paying or is obligated to pay [child] support in more than one jurisdiction, (II) checking of records of such individuals on a periodic basis with Federal, intra- and inter-State, and local agencies, (III) maintaining the data necessary to meet the Federal reporting requirements on a timely basis, and (IV) delinquency and enforcement activities), (ii) the collection and distribution of support payments (both intra- and inter-State), the determination, collection and distribution, of incentive payments both inter- and intra-State, and the maintenance of accounts receivable

on all amounts owed, collected and distributed, and (iii) the costs of all services rendered, either directly or by interfacing with State financial management and expenditure information, (B) to provide interface with records of the State's aid to families with dependent children program in order to determine if a collection of a support payment causes a change affecting eligibility for or the amount of aid under such program, (C) to provide for security against unauthorized access to, or use of, the data in such system, and (D) to provide management information on all cases under the State plan from initial referral or application through collection and enforcement; [and]

(17) in the case of a State which has in effect an agreement with the Secretary entered into pursuant to section 463 for the use of the Parent Locator Service established under section 453, to accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, and to impose and collect (in accordance with regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, to transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect, otherwise to comply with such agreement and regulations of the Secretary with respect thereto[.];

(18) *provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 464, and take all steps necessary to implement and utilize such procedures; and*

(19) *provide that a fee shall be imposed on the individual who owes a child or spousal support obligation, in accordance with State law, with respect to all such child and spousal support obligations for which collection is made by the State agency under this part on behalf of an individual not otherwise eligible for collection services (as determined for purposes of paragraph (6)) in an amount equal to 10 percent of the amount so owed (and for purposes of this part, no part of the amount collected shall be considered to be a fee collected except amounts which exceed the actual amount of support owed).*

Payments to States

Sec. 455. (a) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter, beginning with the quarter commencing July 1, 1975, an amount—

(1) equal to 75 percent of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454,

(2) equal to 50 percent of the total amounts expended by such State during such quarter for the operation of a plan which meets the conditions of section 454 except as is provided by a waiver

by the Secretary which is granted pursuant to specific authority set forth in the law, and

(3) equal to 90 percent (rather than the percent specified in clause (1) or (2)) of so much of the sums expended during such quarter as are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system which the Secretary finds meets the requirements specified in section 454(16);

except that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 463. *In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.*

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) Subject to subsection (d), the Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c)(1) Subject to paragraph (2), there shall be included, in determining amounts expended by a State during any quarter for the operation of the plan approved under section 454, so much of the expenditures of course of such State and its political subdivisions (excluding expenditures for or in connection with judges and other individuals making judicial determinations, but not excluding expenditures for or in connection with their administrative and support personnel) as are attributable to the performance of services which are directly related to, and clearly identifiable with, the operation of such plan.

(2) The aggregate amount of the expenditures which are included pursuant to paragraph (1) for the quarters in any calendar year shall be reduced (but not below zero) by the total amount of expenditures described in paragraph (1) which were made by the State for the 12-month period beginning January 1, 1978.

(3) The State agency may, if the law (or procedures established thereunder) of the State so provides, pay so much of the amount it

receives under subsection (a) for any quarter as is payable by reason of the provisions of this subsection directly to the courts of the State (or political subdivisions thereof) furnishing the services on account of which the payment is payable.

(d) Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).

Support Obligations

Sec. 456. (a) The support rights assigned to the State under section 402(a) (26) shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

(1) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by the State in accordance with a formula approved by the Secretary, and

(2) Any amounts collected from an absent parent under the plan shall reduce, dollar for dollar, the amount of his obligation under paragraphs (1) (A) and (B).

(b) [Repealed].

(b) *A debt which is a child support obligation assigned to a State under section 402(a) (26) is not released by a discharge in bankruptcy under title 11, United States Code.*

Distribution of Proceeds

Sec. 457. (a) The amounts collected as child support by a State pursuant to a plan approved under this part during the 15 months beginning July 1, 1975, shall be distributed as follows:

(1) 40 per centum of the first \$50 of such amounts as are collected periodically which represent monthly support payments shall be paid to the family without any decrease in the amount paid as assistance to such family during such month;

(2) such amounts as are collected periodically which are in excess of any amount paid to the family under paragraph (1) which represent monthly support payments shall be retained by the State to reimburse it for assistance payments to the family during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(3) such amounts as are in excess of amounts retained by the State under paragraph (2) and are not in excess of the amount required to be paid during such period to the family by a court order shall be paid to the family; and

(4) such amounts as are in excess of amounts required to be distributed under paragraph (1), (2), and (3) shall be (A) retained by the State (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing) as reimbursement for any past assistance payments made to the family for which the State has not been reimbursed or (B) if no assistance payments have been made by the State which have not been repaid, such amounts shall be paid to the family.

(b) The amounts collected as [child] support by a State pursuant to a plan approved under this part during any fiscal year beginning after September 30, 1976, shall be distributed as follows:

(1) such amounts as are collected periodically which represent monthly support payments shall be retained by the State to reimburse it for assistance payments to the family during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(2) such amounts as are in excess of amounts retained by the State under paragraph (1) and are not in excess of the amount required to be paid during such period to the family by a court order shall be paid to the family; and

(3) such amounts as are in excess of amounts required to be distributed under paragraphs (1) and (2) shall be (A) retained by the State (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing) as reimbursement for any past assistance payments made to the family for which the State has not been reimbursed or (B) if no assistance payments have been made by the State which have not been repaid, such amounts shall be paid to the family.

(c) Whenever a family for whom [child] support payments have been collected and distributed under the plan ceases to receive assistance under part A of this title, the State may—

(1) continue to collect amounts of [child] support payments which represent monthly support payments from the absent parent for a period of not to exceed three months from the month following the month in which such family ceased to receive assistance under part A of this title, and pay all amounts so collected, which represent monthly support payments, to the family; and

(2) at the end of such three-month period, if the State is authorized to do so by the individual on whose behalf the collection will be made, continue to collect amounts of [child] support payments which represent monthly support payments from the absent parent and pay the net amount of any amount so collected, which represents monthly support payments, to the family after deducting any costs incurred in making the collection from the amount of any recovery made,

and so much of any amounts of [child] support so collected as are in excess of the payments required to be made in paragraph (1) shall be distributed in the manner provided by subsection (b) (3) (A) and (B) with respect to excess amounts described in subsection (b).

Civil Actions To Enforce [Child] Support Obligations

Sec. 460. The district courts of the United States shall have jurisdiction, without regard to any amount in controversy, to hear and determine any civil action certified by the Secretary of Health, Education, and Welfare under section 452(a) (8) of this Act. A civil action under this section may be brought in any judicial district in which the claim arose, the plaintiff resides, or the defendant resides.

* * * * *

Collection of Past-Due Support From Federal Tax Refunds

Sec. 464. (a) *Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which has been assigned to such State pursuant to section 402 (a) (26), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to the past-due support, and pay such amount to the State agency (together with notice of the individual's home address) for distribution in accordance with section 457 (b) (3).*

(b) *The Secretary of the Treasury shall issue regulations, approved by the Secretary of Health and Human Services, prescribing the time or times at which States must submit notices of past-due support, the manner in which such notices must be submitted, and the necessary information that must be contained in or accompany the notices. The regulations shall specify the minimum amount of past-due support to which the offset procedure established by subsection (a) may be applied, and the fee that a State must pay to reimburse the Secretary of the Treasury for the full cost of applying the offset procedure, and provide that the Secretary of the Treasury will advise the Secretary of Health and Human Services, not less frequently than annually, of the States which have furnished notices of past-due support under subsection (a), the number of cases in each State with respect to which such notices have been furnished, the amount of support sought to be collected under this subsection by each State, and the amount of such collections actually made in the case of each State.*

(c) *As used in this part the term "past-due support" means the amount of a delinquency, determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a child, or of a child and the parent with whom the child is living.*

[Part E—Federal Payments for Foster Care and Adoption Assistance

[Purpose: Appropriation

[Sec. 470. For the purpose of enabling each State to provide, in appropriate cases, foster care and adoption assistance for children who otherwise would be eligible for assistance under the State's plan ap-

proved under part A (or, in the case of adoption assistance, would be eligible for benefits under title XVI), there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

[State Plan for Foster Care and Adoption Assistance

[Sec. 471. (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

[(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance payments in accordance with section 473;

[(2) provides that the State agency responsible for administering the program authorized by part B of this title shall administer, or supervise the administration of, the program authorized by this part;

[(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

[(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law;

[(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

[(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as the "State agency") will make such reports, in such form and containing such information as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

[(7) provides that the State agency will monitor and conduct periodic evaluations of activities carried out under this part:

[(8) provides safeguards which restrict the use of or disclosure of information concerning individuals assisted under the State plan to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under part A, B, C, or D of this title or under title I, V, X, XIV, XVI (as in effect in Puerto Rico, Guam, and the Virgin Islands), XIX, or XX, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connec-

tion with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, and (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental agency which is authorized by law to conduct such audit or activity; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an agency referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; except that nothing contained herein shall preclude a State from providing standards which restrict disclosures to purposes more limited than those specified herein, or which, in the case of adoptions, prevent disclosure entirely;

[(9) provides that where any agency of the State has reason to believe that the home or institution in which a child resides whose care is being paid for in whole or in part with funds provided under this part or part B of this title is unsuitable for the child because of the neglect, abuse, or exploitation of such child, it shall bring such condition to the attention of the appropriate court or law enforcement agency;

[(10) provides that the standards referred to in section 2003 (d) (1) (F) shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B of this title;

[(11) provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance payments to assure their continuing appropriateness;

[(12) provides for granting an opportunity for a fair hearing before the State agency to any individual whose claim for benefits available pursuant to this part is denied or is not acted upon with reasonable promptness;

[(13) provides that the State shall arrange for a periodic and independently conducted audit of the programs assisted under this part and part B of this title, which shall be conducted no less frequently than once every three years;

[(14) provides (A) specific goals (which shall be established by State law on or before October 1, 1982) for each fiscal year (commencing with the fiscal year which begins on October 1, 1983) as to the maximum number of children (in absolute numbers or as a percentage of all children in foster care with respect to whom assistance under the plan is provided during such year) who, at any time during such year, will remain in foster care after having been in such care for a period in excess of twenty-four months, and (B) a description of the steps which will be taken by the State to achieve such goals;

[(15) effective October 1, 1983, provides that, in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home; and

[(16) provides for the development of a case plan (as defined in section 475(1)) for each child receiving foster care maintenance payments under the State plan and provides for a case review system which meets the requirements described in section 475(5) (B) with respect to each such child.

[(b) The Secretary shall approve any plan which complies with the provisions of subsection (a) of this section. However, in any case in which the Secretary finds, after reasonable notice and opportunity for a hearing, that a State plan which has been approved by the Secretary no longer complies with the provisions of subsection (a), or that in the administration of the plan there is a substantial failure to comply with the provisions of the plan, the Secretary shall notify the State that further payments will not be made to the State under this part, or that such payments will be made to the State but reduced by an amount which the Secretary determines appropriate, until the Secretary is satisfied that there is no longer any such failure to comply, and until he is so satisfied he shall make no further payments to the State, or shall reduce such payments by the amount specified in this notification to the State.

[Foster Care Maintenance Payments Program

[Sec. 472. (a) Each State with a plan approved under this part shall make foster care maintenance payments (as defined in section 475(4)) under this part with respect to a child who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative (specified in section 406(a)), if—

[(1) the removal from the home occurred pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian or was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child and (effective October 1, 1983) that reasonable efforts of the type described in section 471(a) (15) had been made;

[(2) such child's placement and care are the responsibility of (A) the State agency administering the State plan approved under section 471, or (B) any other public agency with whom the State agency administering or supervising the administration of the State plan approved under section 471 has made an agreement which is still in effect;

[(3) such child has been placed in a foster family home or child-care institution as a result of the voluntary placement agreement or judicial determination referred to in paragraph (1); and

[(4) such child—

[(A) received aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

[(B) (i) would have received such aid in or for each month if application had been made therefor, or (ii) had been living with a relative specified in section 406(a) within six months prior to the month in which such agreement was entered into

or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made.

[(b) Foster care maintenance payments may be made under this part only on behalf of a child described in subsection (a) of this section who is—

[(1) in the foster family home of an individual, whether the payments therefor are made to such individual or to a public or nonprofit private child-placement or child-care agency, or

[(2) in a child-care institution, whether the payments therefor are made to such institution or to a public or nonprofit private child-placement or child-care agency, which payments shall be limited so as to include in such payments only those items which are included in the term “foster care maintenance payments” (as defined in section 475(4)).

[(c) For the purposes of this part, (1) the term “foster family home” means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and (2) the term “child-care institution” means a nonprofit private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

[(d) Notwithstanding any other provision of this title, Federal payments may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of children removed from their homes pursuant to voluntary placement agreements as described in subsection (a), only if (at the time such amounts were expended) the State has fulfilled all of the requirements of section 427(b).

[(e) No Federal payment may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of any child who was removed from his or her home pursuant to a voluntary placement agreement as described in subsection (a) and has remained in voluntary placement for a period in excess of 180 days, unless there has been a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) to the effect that such placement is in the best interests of the child.

[(f) For the purposes of this part and part B of this title, (1) the term “voluntary placement” means an out-of-home placement of a minor, by or with participation of a State agency, after the parents or guardians of the minor have requested the assistance of the agency and signed a voluntary placement agreement; and (2) the term “voluntary placement agreement” means a written agreement, binding on

the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which sacrifices, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement.

[(g) In any case where—

[(1) the placement of a minor child in foster care occurred pursuant to a voluntary placement agreement entered into by the parents or guardians of such child as provided in subsection (a), and

[(2) such parents or guardians request (in such manner and form as the Secretary may prescribe) that the child be returned to their home or to the home of a relative,

the voluntary placement agreement shall be deemed to be revoked unless the State agency opposes such request and obtains a judicial determination, by a court of competent jurisdiction, that the return of the child to such home would be contrary to the child's best interests.

[(h) For purposes of titles XIX and XX, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title.

[Adoption Assistance Program

[Sec. 473. (a) (1) Each State with a plan approved under this part shall, directly through the State agency or through another public or nonprofit private agency, make adoption assistance payments pursuant to an adoption assistance agreement in amounts determined under paragraph (2) of this subsection to parents who, after the effective date of this section, adopt a child who—

[(A) (i) at the time adoption proceedings were initiated, met the requirements of section 406(a) or section 407 or would have met such requirements except for his removal from the home of a relative (specified in section 406(a)), either pursuant to a voluntary placement agreement with respect to which Federal payments are provided under section 474 (or 403) or as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child, or

[(ii) meets all of the requirements of title XVI with respect to eligibility for supplemental security income benefits.

[(B) (i) received aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

[(ii) (I) would have received such aid in or for such month if application had been made therefor, or (II) had been living with a relative specified in section 406(a) within six months prior to the month in which such agreement was entered into or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made, or

[(iii) is a child described in subparagraph (A) (ii), and
 [(C) has been determined by the State, pursuant to subsection
 (c) of this section, to be a child with special needs.

[(2) The amount of the adoption assistance payments shall be determined through agreement between the adoptive parents and the State or local agency administering the program under this section, which shall take into consideration the circumstances of the adopting parents and the needs of the child being adopted, and may be readjusted periodically, with the concurrence of the adopting parents (which may be specified in the adoption assistance agreement), depending upon changes in such circumstances. However, in no case may the amount of the adoption assistance payment exceed the foster care maintenance payment which would have been paid during the period if the child with respect to whom the adoption assistance payment is made had been in a foster family home.

[(3) Notwithstanding the preceding paragraph, (A) no payment may be made to parents with respect to any child who has attained the age of eighteen (or, where the State determines that the child has a mental or physical handicap which warrants the continuation of assistance, the age of twenty-one), and (B) no payment may be made to parents with respect to any child if the State determines that the parents are no longer legally responsible for the support of the child or if the State determines that the child is no longer receiving any support from such parents. Parents who have been receiving adoption assistance payments under this section shall keep the State or local agency administering the program under this section informed of circumstances which would, pursuant to this subsection, make them ineligible for such assistance payments, or eligible for assistance payments in a different amount.

[(4) For purposes of this part, individuals with whom a child (who has been determined by the State, pursuant to subsection (c), to be a child with special needs) is placed for adoption, pursuant to an interlocutory decree, shall be eligible for adoption assistance payments under this subsection, during the period of the placement, on the same terms and subject to the same conditions as if such individuals had adopted such child.

[(b) For purposes of title XIX and XX, any child with respect to whom adoption assistance payments are made under this section shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title.

[(c) For purposes of this section, a child shall not be considered a child with special needs unless—

[(1) the State has determined that the child cannot or should not be returned to the home of his parents; and

[(2) the State had first determined (A) that there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance, and (B) that, except where

it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section.

[Payments to States; Allotments to States

[Sec. 474. (a) For each quarter beginning after September 30, 1980, each State which has a plan approved under this part (subject to the limitations imposed by subsection (b)) shall be entitled to a payment equal to the sum of—

[(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as foster care maintenance payments under section 472 for children in foster family homes or child-care institutions; plus

[(2) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as adoption assistance payments under section 473 pursuant to adoption assistance agreements; plus

[(3) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision, and

[(B) one-half of the remainder of such expenditures.

[(b) (1) Notwithstanding the provisions of subsections (a) (1) and (a) (3), the aggregate of the sums payable thereunder to any State (other than a State subject to limitation under section 1108(a)) with respect to expenditures relating to foster care, for the calendar quarters in any of the fiscal years 1981 through 1984 in which the conditions set forth in paragraph (2) are met, shall not exceed the State's allotment for such year.

[(2) (A) The limitation in paragraph (1) shall apply—

[(i) with respect to fiscal year 1981, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than \$163,550,000;

[(ii) with respect to fiscal year 1982, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than \$220,000,000;

[(iii) with respect to fiscal year 1983, only if the amount appropriated under section 420 for such fiscal year is equal to \$266,000,000; and

[(iv) with respect to fiscal year 1984, only if the amount appropriated under section 420 for such fiscal year is equal to \$266,000,000.

[(B) The limitations set forth in paragraph (1) with respect to the fiscal years 1982 through 1984 shall apply only if the required appropriation is made in advance in an appropriation Act (as authorized under section 420(b)) for the fiscal year preceding the fiscal year to which the limitation would apply.

[(3) For purposes of this subsection, a State's allotment for any fiscal year shall be the greater of—

[(A) the amount determined under paragraph (4);

[(B) an amount which bears the same ratio to \$100,000,000 as the under age eighteen population of such State bears to the under age eighteen population of the fifty States and the District of Columbia; or

[(C) at the option of the State, an amount determined under paragraph (5), but only in the case of a State which meets the requirements of such paragraph (5).

[(4) For purposes of paragraph (3) (A), a State's allotment shall be determined as follows:

[(A) The allotment for any State for fiscal year 1980 shall be an amount equal to such State's base amount (as determined under subparagraph (C)) increased by 21.2 percent.

[(B) The allotment for any State for each of the fiscal years 1981 through 1984 shall be an amount equal to such State's allotment for the preceding fiscal year, increased or decreased by a percentage equal to twice the percentage increase or decrease (as the case may be) (but not to exceed an increase or decrease of 10 percent) in the Consumer Price Index prepared by the Department of Labor, and used in determining cost-of-living adjustments under section 215(i) of this Act, for the second quarter of the preceding fiscal year as compared to such index for the second quarter of the second preceding fiscal year. For purposes of this subparagraph the Consumer Price Index for any quarter shall be the arithmetical means of such index for the three months in such quarter.

[(C) The base amount shall be equal to the amount of the Federal funds payable to such State for fiscal year 1978 under section 403 on account of expenditures for aid with respect to which Federal financial participation is authorized in payments pursuant to section 408 (including administrative expenditures attributable to the provision of such aid as determined by the Secretary) and for those States which in fiscal year 1978 did not make foster care maintenance payments under section 408 on behalf of children otherwise eligible for such payment, solely because their foster care was provided by related persons, shall be equal to the total amount of Federal funds the State would have been entitled to be paid under section 403 on account of expenditures pursuant to section 408 for that fiscal year if such payments had been made. In the event that there is a dispute between any State and the Secretary as to the amount of such expenditures for such fiscal year, then, until the beginning of the fiscal year immediately following

the fiscal year in which the dispute is finally resolved, the base amount shall be deemed to be the amount of Federal funds which would have been payable under section 403 if the amount of such expenditures were equal to the amount thereof claimed by the State.

[(5) (A) For purposes of paragraph (3) (C), a State's allotment for any fiscal year ending after September 30, 1980, and before October 1, 1984, may, at the option of the State (and if the State meets the requirements of subparagraphs (B) and (C)), be determined by application of the provisions of paragraph (4) with the following modifications:

[(i) The base amount for purposes of determining an allotment for any such fiscal year shall be equal to the base amount determined under paragraph (4) (C) increased by a percentage equal to the percentage by which the average monthly number of children in such State receiving aid with respect to which Federal financial participation is authorized in payments pursuant to section 408, or receiving foster care maintenance payments with respect to which Federal financial participation is authorized under this part, for such fiscal year exceeds the average monthly number of such children for fiscal year 1978.

[(ii) For purposes of clause (i), the percentage determined under such clause shall not exceed 33.1 percent in the case of fiscal year 1981, 46.4 percent in the case of fiscal year 1982, 61.1 percent in the case of fiscal year 1983, or 77.2 percent in the case of fiscal year 1984.

[(B) No State may exercise the option to have its allotment amount determined under the provisions of this paragraph unless, for fiscal year 1978, the average monthly number of children in such State receiving aid for which Federal financial participation is authorized in payments pursuant to section 408 as a percentage of the under age eighteen population of such State, was less than the average such percentage for the fifty States and the District of Columbia.

[(C) No State may exercise the option to have its allotment determined under this paragraph for any fiscal year other than fiscal year 1981 after the first fiscal year (after fiscal year 1978) with respect to which the average monthly number of children in such State receiving aid for which Federal financial participation is authorized in payments pursuant to section 408, or receiving foster care maintenance payments for which Federal financial participation is authorized under this part, as a percentage of the under age eighteen population of such State, was equal to or greater than the average such percentage for the fifty States and the District of Columbia for the fiscal year 1978. Any allotment determined under this paragraph for a State which opted to have its allotment so determined under this paragraph for the fiscal year prior to the fiscal year for which its option may not be exercised by reason of the preceding sentence shall be considered to be such State's allotment for such prior fiscal year for purposes of determining allotments for subsequent fiscal years under paragraph (4).

[(D) In determining the number of children receiving aid for which Federal financial participation is authorized in payments under

section 408 or under this part, for any fiscal year, with respect to any State and with respect to the national average for purposes of subparagraphs (B) and (C), there shall be included those children with respect to whom foster care maintenance payments were not made under section 408 or this part (though they were otherwise eligible for such payments) solely because their foster care was provided by related persons. In the event that there is a dispute between any State and the Secretary as to the number of such children (with respect to whom foster care maintenance payments were not made) for any fiscal year, then until the beginning of the fiscal year immediately following the fiscal year in which the dispute is finally resolved, determinations under subparagraphs (B) and (C) shall be made on the basis of the number of such children claimed by the State.

[(E) The Secretary shall promulgate an interim allotment amount for purposes of this paragraph for each fiscal year for each State exercising its option to have its allotment determined under this paragraph, based on the most recent satisfactory data available, not later than six months after the beginning of such fiscal year. The amount of such allotment shall be adjusted, and the final allotment amount shall be promulgated, based on the most recent satisfactory data available, not later than nine months after the end of such fiscal year.

[(6) Except in the case of a State which loses the option of having its allotment determined under paragraph (5) by reason of the provisions of paragraph (5) (C), and subject to the provisions of such paragraph (5) (C), the amount of any allotment as determined in accordance with subparagraph (A), (B), or (C) of paragraph (3) for any fiscal year for any State shall be determined in accordance with the provisions of such subparagraph, without regard to the amount of such State's allotment for any prior fiscal year as determined in accordance with another such subparagraph.

[(c) (1) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1984 during which the limitation under subsection (b) (1) is in effect, sums available to a State from its allotment under subsection (b) for carrying out this part, which the State does not claim as reimbursement for expenditures in such year pursuant to subsection (a) of this section, may be claimed by the State as reimbursement for expenditures in such year pursuant to part B of this title, in addition to sums available pursuant to section 420 for carrying out part B.

[(2) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1984 during which the limitation under subsection (b) (1) is not in effect, a State may claim as reimbursement for expenditures for such year pursuant to part B of this title, in addition to amounts claimed under section 420, an amount equal to the amount by which the State's allotment amount for such fiscal year (as determined under subsection (b) (3)) exceeds the amount claimed by such State for such fiscal year as reimbursement for expenses relating to foster care under subsection (a) ; except that the total amount claimed by such State for such fiscal year under this paragraph, when added to the amount that such State receives for such fiscal year under section 420, may not exceed the amount that would have been payable to such

State under section 420 for each fiscal year if the relevant amount described in subsection (b) (2) (A) had been appropriated for such fiscal year.

[(3) The provisions of paragraphs (1) and (2) shall not apply for any fiscal year with respect to any State which, with respect to such fiscal year, exercised its option to have its allotment amount determined under subsection (b) (5).

[(4) (A) No State may claim an amount under the provisions of this subsection as reimbursed for expenditures for any fiscal year pursuant to part B of this title to the extent that such amount, plus the amount claimed by such State for such fiscal year under section 420, exceeds the amount which would be allotted to such State under part B if the amount appropriated under section 420 were \$141,000,000, unless such State has met the requirements set forth in section 427 (a).

[(B) If, for each of any two consecutive fiscal years, there is appropriated under section 420 a sum equal to \$266,000,000, no State may claim any amount under the provisions of this subsection as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427 (b).

[(C) If, for each of any two fiscal years during which the limitation under subsection (b) (1) is not in effect, the total amount claimed by a State as reimbursement for expenditures pursuant to part B under this subsection and under section 420 equals the amount which would be allotted to such State for such fiscal year under part B if the amount appropriated under section 420 were \$266,000,000, such State may not claim any amount under the provisions of paragraph (2) as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427 (b).

[(d) (1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (c) such other investigation as the secretary may find necessary.

[(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

[(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect of foster care and adoption assistance furnished under

the State plan shall be considered an overpayment to be adjusted under this subsection.

[Definitions

[Sec. 475. As used in this part or part B of this title :

[(1) The term "case plan" means a written document which includes at least the following: A description of the type of home or institution in which a child is to be placed, including a discussion of the appropriateness of the placement and how the agency which is responsible for the child plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child in accordance with section 472(a)(1) and a plan for assuring that the child receives proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan.

[(2) The term "parents" means biological or adoptive parents or legal guardians, as determined by applicable State law.

[(3) The term "adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the State agency, other relevant agencies, and the prospective adoptive parents of a minor child which as a minimum (A) specifies the amounts of the adoption assistance payments and any additional services and assistance which are to be provided as part of such agreement, and (B) stipulates that the agreement shall remain in effect regardless of the State of which the adoptive parents are residents at any given time. The agreement shall contain provisions for the protection (under an interstate compact approved by the Secretary or otherwise) of the interests of the child in cases where the adoptive parents and child move to another State while the agreement is effective.

[(4) The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

[(5) The term "case review system" means a procedure for assuring that—

[(A) each child has a case plan designed to achieve placement in the least restrictive (most family like) setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child.

[(B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review (as defined in paragraph (6)) in order to determine the continuing necessity for and appropriateness of the placement, the extent of compliance

with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement in foster care, and to project a likely date by which the child may be returned to the home or placed for adoption or legal guardianship, and

[(C) with respect to each such child, procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a dispositional hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than eighteen months after the original placement (and periodically thereafter during the continuation of foster care), which hearing shall determine the future status of the child (including, but not limited to, whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should (because of the child's special needs or circumstances) be continued in foster care on a permanent or long-term basis); and procedural safeguards shall also be applied with respect to parental rights pertaining to the removal of the child from the home of his parents, to a change in the child's placement, and to any determination affecting visitation privileges of parents.

[(6) The term "administrative review" means a review open to the participation of the parents of the child, conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

[Technical Assistance; Data Collection and Evaluation

[Sec. 476. (a) The Secretary may provide technical assistance to the States to assist them to develop the programs authorized under this part and shall periodically (1) evaluate the programs authorized under this part and part B of this title and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country.

[(b) Each State shall submit statistical reports as the Secretary may require with respect to children for whom payments are made under this part containing information with respect to such children including legal status, demographic characteristics, location, and length of any state in foster care.

[TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

[Authorization of Appropriations

[Sec. 501. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State,

[(1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and

[(2) services for locating, and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling,

there are authorized to be appropriated \$250,000,000 for the fiscal year ending June 30, 1969, \$275,000,000 for the fiscal year ending June 30, 1970, \$300,000,000 for the fiscal year ending June 30, 1971, \$325,000,000 for the fiscal year ending June 30, 1972, \$350,000,000 for the fiscal year ending June 30, 1973, and for each of the next four fiscal years, and \$399,864,200 for the fiscal year ending September 30, 1978, and for each fiscal year thereafter.

[Purposes for Which Funds Are Available

[Sec. 502. Appropriations pursuant to section 501 shall be available for the following purposes in the following proportions:

[(1) In the case of the fiscal year ending June 30, 1969, and each of the next 5 fiscal years, (A) 50 percent of the appropriation for such year shall be for allotments pursuant to sections 503 and 504; (B) 40 percent thereof shall be for grants pursuant to sections 508, 509, and 510; and (C) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

[(2) In the case of the fiscal year ending June 30, 1975, and each fiscal year thereafter, (A) 90 percent of the appropriation for such years shall be for allotments pursuant to sections 503 and 504; and (B) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

Not to exceed 5 percent of the appropriation for any fiscal year under this section shall be transferred, at the request of the Secretary, from one of the purposes specified in paragraph (1) or (2) to another purpose or purposes so specified. For each fiscal year, the Secretary shall determine the portion of the appropriation, within the percentage determined above to be available for sections 503 and 504, which shall be available for allotment pursuant to section 503 and the portion thereof which shall be available for allotment pursuant to section 504. Notwithstanding the preceding provisions of this section, of the amount appropriated for any fiscal year pursuant to section 501, not less than 6 percent of the amount appropriated shall be available for family planning services from allotments under section 503 and for family planning services under projects under sections 508 and 512.

[Allotments to States for Maternal and Child Health Services

[Sec. 503. The amount determined to be available pursuant to section 502 for allotments under this section shall be allotted for payments for maternal and child health services as follows:

[(1) One-half of such amount shall be allotted by allotting to each State \$70,000 plus such part of the remainder of such one-half as he finds that the number of live births in such State bore to

the total number of live births in the United States in the latest calendar year for which he has statistics.

[(2) The remaining one-half of such amount shall (in addition to the allotments under paragraph (1)) be allotted to the States from time to time according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary after taking into consideration the number of live births in such State; except that not more than 25 percent of such one-half shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of maternal and child health.

[Allotments to States for Crippled Children's Services

[Sec. 504. The amount determined to be available pursuant to section 502 for allotments under this section shall be allotted for payments for crippled children's services as follows:

[(1) One-half of such amount shall be allotted by allotting to each State \$70,000 and allotting the remainder of such one-half according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in paragraph (2) of section 501 and the cost of furnishing such services to them.

[(2) The remaining one-half of such amount shall (in addition to the allotments under paragraph (1)) be allotted to the States from time to time according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary after taking into consideration the number of crippled children in each State in need of the services referred to in paragraph (2) of section 501 and the cost of furnishing such services to them; except that not more than 25 percent of such one-half shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of services for crippled children.

[Approval of State Plans

[Sec. 505. (a) In order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

[(1) provides for financial participation by the State;

[(2) provides for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; except that in the case of those States which on July 1, 1967, provided for administration (or supervision thereof) of the State plan approved under section

513 (as in effect on such date) by a State agency other than the State health agency, the plan of such State may be approved under this section if it would meet the requirements of this subsection except for provision of administration (or supervision thereof) by such other agency for the portion of the plan relating to services for crippled children, and, in each such case, the portion of such plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title;

[(3) provides (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan and (B) provides for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency;

[(4) provides that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

[(5) provides for cooperation with medical, health, nursing, educational, and welfare groups and organizations and, with respect to the portion of the plan relating to services for crippled children, with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children;

[(6) provides for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII;

[(7) provides, with respect to the portion of the plan relating to services for crippled children, for early identification of children in need of health care and services, and for health care and treatment needed to correct or ameliorate defects or chronic conditions discovered thereby, through provision of such periodic screening and diagnostic services, and such treatment, care and other measures to correct or ameliorate defects or chronic conditions, as may be provided in regulations of the Secretary;

[(8) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 508 which offers reasonable assurance, particularly in

areas with concentrations of low-income families, of satisfactorily helping to reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with child bearing and of satisfactorily helping to reduce infant and maternal mortality;

[(9) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 509 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the health of children and youth of school or preschool age;

[(10) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 510 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the dental health of children and youth of school or preschool age;

[(11) provides for carrying out the purposes specified in section 501;

[(12) provides for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need;

[(13) provides that, where payment is authorized under the plan for services which an optometrist is licensed to perform, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from an optometrist licensed to perform such services except where such services are rendered in a clinic, or another appropriate institution, which does not have an arrangement with optometrists so licensed;

[(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan;

[(15) provides—

[(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

[(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title; and

[(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).

[(b) The Secretary shall approve any plan which meets the requirements of subsection (a).]

[Payments]

[Sec. 506. (a) From the sums appropriated therefor and the allotments available under section 503(1) or 504(1), as the case may be, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing July 1, 1968, an amount which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan with respect to maternal and child health services and services for crippled children, respectively.

[(b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

[(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

[(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[(c) The Secretary shall also from time to time make payments to the States from their respective allotments pursuant to section 503(2) or 504(2). Payments of grants under sections 503(2), 504(2), 508, 509, 510, and 511, and of grants, contracts, or other arrangements under section 512, may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the section involved.

[(d) The total amount determined under subsections (a) and (b) and the first sentence of subsection (c) for any fiscal year ending after

June 30, 1968, shall be reduced by the amount by which the sum expended (as determined by the Secretary) from non-Federal sources for maternal and child health services and services for crippled children for such year is less than the sum expended from such sources for such services for the fiscal year ending June 30, 1968. In the case of any such reduction, the Secretary shall determine the portion thereof which shall be applied, and the manner of applying such reduction, to the amounts otherwise payable from allotments under section 503 or section 504.

[(e) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder from the allotments under section 503 or section 504 for any period after June 30, 1968, unless the State makes a satisfactory showing that it is extending the provisions of services, including services for dental care for children and family planning for mothers, to which such State's plan applies in the State with a view to making such services available by July 1, 1975, to children and mothers in all parts of the State.

[(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—

[(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b) (3) ; or

[(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d) (1) or under clause (D), (E), or (F) of section 1866(b) (2) ; or

[(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

[(4) with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirement imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph in any State if the State agency demonstrates to his

satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861 (k).

[(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or area-wide planning agency, see section 1122.

[Operation of State Plans

[Sec. 507. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

[(1) that the plan has been so changed that it no longer complies with the provisions of section 505; or

[(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[Special Project Grants for Maternity and Infant Care

[Sec. 508. (a) In order to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality, the Secretary is authorized to make, from the sums available under clause (B) of paragraph (1) of section 502, grants to the State health agency of any State and, with the consent of such agency, to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75 percent of the cost (exclusive of general agency overhead) of any project for the provision of—

[(1) necessary health care to prospective mothers (including, after childbirth, health care to mothers and their infants) who have or are likely to have conditions associated with childbearing or are in circumstances which increase the hazards to the health of the mothers or their infants (including those which may cause physical or mental defects in the infants), or

[(2) necessary health care to infants during their first year of life who have any condition or are in circumstances which increase the hazards to their health, or

[(3) family planning services,

but only if the State or local agency determines that the recipient will not otherwise receive such necessary health care or services because he is from a low-income family or for other reasons beyond his control. Acceptance of family planning services provided under a project under this section (and section 512) shall be voluntary on the part of the indi-

vidual to whom such services are offered and shall not be a prerequisite to the eligibility for or the receipt of any service under such project.

[(b) No grant may be made under this section for any project for any period after June 30, 1974.

[Special Project Grants for Health of School and Preschool Children

[Sec. 509. (a) In order to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, the Secretary is authorized to make, from the sums available under clause (B) of paragraph (1) of section 502, grants to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 505, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). No project shall be eligible for a grant under this section unless it provides (1) for the coordination of health care and services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare, and education programs for such children, (2) for payment of (A) the reasonable cost (as determined in accordance with standards, consistent with section 1122, approved by the Secretary) of inpatient hospital services provided under the project, or (B) if less, the customary charges with respect to such services provided under the project, or (C) if such services are furnished under the project by a public institution free of charge or at nominal charges to the public, an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such institution for such services, and (3) that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and no such project for children and youth of school age shall be considered to be of a comprehensive nature for purposes of this section unless it includes (subject to the limitation in the preceding provisions of this sentence) at least such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

[(b) No grant may be made under this section for any project for any period after June 30, 1974.

[Special Project Grants for Dental Health of Children

[Sec. 510. (a) In order to promote the dental health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, the Secretary is authorized to make

grants, from the sums available under clause (B) of paragraph (1) of section 502, to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, and to any other public or nonprofit private agency, institution, or organization, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for dental care and services for children and youth of school age or for preschool children. No project shall be eligible for a grant under this section unless it provides that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control, and unless it includes (subject to the limitation of the foregoing provisions of this sentence) at least such preventive services, treatment, correction of defects, and aftercare, for such age groups, as may be provided in regulations of the Secretary. Such projects may also include research looking toward the development of new methods of diagnosis or treatment, or demonstration of the utilization of dental personnel with various levels of training.

[(b) No grant may be made under this section for any project for any period after June 30, 1974.

[Training of Personnel]

[Sec. 511. From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps. In making such grants the Secretary shall give special attention to programs providing training at the undergraduate level.

[Research Projects Relating to Maternal and Child Health Services and Crippled Children's Services]

[Sec. 512. From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to or jointly financed cooperative arrangements with public or other nonprofit institutions of higher learning, and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or crippled children's programs, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof. Effective with respect to grants made and arrangements entered into after June 30, 1968, (1) special emphasis shall be accorded to projects which will help in studying the need for, and the feasibility, costs, and effectiveness of, comprehensive health care programs in which maximum use is made of health personnel with varying levels of training, and in studying methods of training for such programs, and (2) grants under this section may also include funds for the training of health personnel for work in such projects.

[Administration]

[Sec. 513. (a) The Secretary of Health, Education, and Welfare shall make such studies and investigations as will promote the efficient administration of this title.

[(b) Such portion of the appropriations for grants under section 501 as the Secretary may determine, but not exceeding one-half of 1 percent thereof, shall be available for evaluation by the Secretary (directly or by grants or contracts) of the programs for which such appropriations are made and, in the case of allotments from any such appropriations, the amount available for allotments shall be reduced accordingly.

[(c) Any agency, institution, or organization shall, if and to the extent prescribed by the Secretary, as a condition to receipt of grants under this title, cooperate with the State agency administering or supervising the administration of the State plan approved under title XIX in the provision of care and services, available under a plan or project under this title, for children eligible therefor under such plan approved under title XIX.

[Definition]

[Sec. 514. For purposes of this title, a crippled child is an individual under the age of 21 who has an organic disease, defect, or condition which may hinder the achievement of normal growth and development.

[Observance of Religious Beliefs]

[Sec. 515. Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

[Supplemental Allotments]

[Sec. 516. (a) (1) For each fiscal year (commencing with the fiscal year ending June 30, 1975), there shall (subject to paragraph (2)) be allotted to each State (from funds appropriated for such fiscal year pursuant to subsection (b)) an amount, which shall be in addition to and available for the same purposes as the allotments of such State (as determined under sections 503 and 504), equal to the excess (if any) of—

[(A) the amount of the allotment of such State (as determined under sections 503 and 504) for the fiscal year ending June 30, 1973, plus the amounts of any grants to such States under sections 508, 509, and 510, over

[(B) the amount of the allotment of such State (as determined under sections 503 and 504) for such fiscal year which commences after June 30, 1973.

[(2) No State shall receive an allotment under this section for any fiscal year, unless such State (in the administration of its State plan, approved under section 505) has in effect arrangements which the Secretary finds will provide for the continuation of appropriate services to population groups previously receiving services from funds made available (for the fiscal year ending June 30, 1974) to such State pursuant to sections 508, 509, and 510.

[(b) (1) (A) There are (subject to subparagraph (B)) hereby authorized to be appropriated for each fiscal year (commencing with the fiscal year ending June 30, 1975) such amounts as may be necessary to enable the Secretary to make the allotments authorized under subsection (a).

[(B) Nothing contained in subparagraph (A) shall be construed to authorize, for any fiscal year, the appropriation under this subsection of any amount which is in excess of the amount by which—

[(i) the amount authorized to be appropriated under section 501 for such year exceeds

[(ii) the total amounts appropriated pursuant to section 501 for such year.

[(2) If, for any fiscal years, the total amount appropriated pursuant to paragraph (1) is less than the total amount allotted to all States under subsection (a), then the amount of the allotment of each State (as determined under subsection (a)) shall be reduced to an amount which bears the same ratio to the total amount appropriated pursuant to paragraph (1) for such fiscal year as the amount of the allotment of such State (as determined under subsection (a)) bears to the total amount allotted to all States under subsection (a) for such fiscal year.]

TITLE V—BLOCK GRANTS FOR MATERNAL AND CHILD HEALTH

Purposes of Title; Authorization of Appropriations

Sec. 501. (a) *For the purpose of enabling each State to—*

(1) *assure mothers and children (in particular those living in poverty or with limited availability of health services) access to quality maternal and child health services at a reasonable cost;*

(2) *provide services for reducing infant mortality and handicapping conditions, reducing the costs of inpatient or long-term care services, and otherwise promoting the health of mothers and children (especially by providing preventive and primary care services for children, and prenatal, delivery, and postpartum care for mothers);*

(3) *provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling;*

(4) *provide services related to hemophilia (without regard to age), lead-based paint poisoning prevention, genetic diseases, and sudden infant death syndrome; and*

(5) *provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI of this Act;*

there are authorized to be appropriated \$334,500,000 for the fiscal year ending September 30, 1982, and for each year thereafter.

(b) (1) *Of the amount appropriated under subsection (a), the Secretary shall retain an amount equal to 10 percent thereof in the case of fiscal year 1982, and an amount not to exceed 10 percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out special projects of regional and national significance, training, and research.*

(2) *For purposes of paragraph (1)—*

(A) *amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children; and*

(B) *amounts retained by the Secretary for research shall be used to make grants to, or jointly financed cooperative arrangements with public or nonprofit institutions of higher learning, and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or crippled children's programs, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement thereof.*

(c) *The Secretary shall designate an organization within the Department of Health and Human Services, which shall be responsible for—*

(1) *the Federal discretionary grants program described in subsection (b) (1);*

(2) *promoting coordination at the Federal level of the activities authorized under this title and under title XIX of this Act, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;*

(3) *disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;*

(4) *providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation; and*

(5) *assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections 505 and 506.*

Allotments

Sec. 502. (a) *From the amounts appropriated under section 501 for any fiscal year, and available for allotment to States after the application of section 501(b), the Secretary shall allot to each State an*

amount which bears the same ratio to such amount available for allotment as the amounts provided or allotted by the Secretary to such State and to entities in such State for fiscal year 1981 under this title, section 1615 (e) of this Act, parts A and B of title XI of the Public Health Service Act, and section 316 of the Public Health Service Act (as those provisions were in effect for fiscal year 1981) bore to the amounts provided or allotted by the Secretary under those provisions to all States and to entities in all States for fiscal year 1981.

(b) If the ratio of—

(1) the amount expended by a State from State funds (other than the grant received under this title) for a fiscal year, for the purposes described in section 501, to

(2) the amount such State would otherwise receive (but for the provisions of this subsection) under section 503 for such fiscal year,

is less than the ratio of—

(3) the amount of State funds (not reimbursed by the Federal Government) which such State government was required to expend in fiscal year 1981 in order to receive its funding for fiscal year 1981 under this title, to

(4) the amount of Federal funds received by such State for fiscal year 1981 under this title, and under section 316 and title XI of the Public Health Service Act,

then the amount otherwise payable under section 503 for such fiscal year shall be reduced by an amount necessary to assure that such ratio for such fiscal year is equal to such ratio for fiscal year 1981.

(c) The Secretary shall conduct a study for the purpose of devising a formula for equitable distribution of funds available for allotment to the States under this title in accordance with criteria specified in subsections (a) and (b). Prior to September 30, 1982, the Secretary shall submit a report to the Congress regarding the development of such formula and make such recommendations as he may deem appropriate in order to insure the most equitable distribution of such funds to the States.

Payments to States

Sec. 503. The Secretary shall make payments as provided by section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213) to each State from its allotment under section 502 from amounts appropriated for any fiscal year.

Use of Grant Money

Sec. 504. (a) A State may use amounts paid to it under section 503 (and amounts transferred under other provisions of law for use under this title) for any of the purposes set forth in section 501, including planning, administration, education, and evaluation, except as limited under subsection (b) or as provided under subsection (c).

(b) Amounts described in subsection (a) may not be used for—

(1) cash payments to intended recipients of health services;

(2) the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

- (3) *satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or*
 (4) *inpatient services to the extent disapproved by the Secretary.*

The Secretary may waive the limitation contained in paragraph (2) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

(c) From the amounts paid to it under section 503 from amounts appropriated for a fiscal year, a State may transfer up to 10 percent for use under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or social services, or for meeting home energy and emergency assistance needs if such other provision of law allows funds to be transferred for use under this title. The State shall inform the Secretary of any such transfer of funds.

(d) Amounts described in subsection (a) shall remain available for expenditure by the State until the end of the fiscal year following the fiscal year for which they were appropriated.

(e) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is appropriate in carrying out the purposes referred to in such subsection.

Report on Intended Expenditures

Sec. 505. *Prior to expenditure by a State of payments made to it under section 503 for any fiscal year, the State shall prepare a report on the intended use of payments the State is to receive under this title, including a consideration of the needs of the State for the services referred to in section 501(a), a statement of goals and objectives for meeting those needs, information on the types of services to be provided and the categories or characteristics of individuals to be served, and a description of the progress made in meeting the State's service and outcome goals. The report shall be made available to the Secretary and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the assessed needs and the activities assisted under this title, and any revision shall be subject to the requirements of the preceding sentence.*

Reports and Audits

Sec. 506. *(a) Each State shall prepare reports on its activities under this title. Reports shall be in such form, contain such information, and be of such frequency (not less often than every two years) as the State finds necessary to secure an accurate description of those activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were expended consistent with the reports required by section 505. The State shall*

make copies of the reports required by this section available for public inspection within the State. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(b) Each State shall, not less often than every two years, audit its expenditures from amounts received under (or transferred to) this title. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this title, in accordance with generally accepted auditing principles. Within thirty days following the completion of each audit report, the State shall submit a copy of that audit report to the legislature of the State, to appropriate State agencies, and to the Secretary. Each State shall repay to the United States amounts found by the Secretary on the basis of such audit, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this title or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

(c) The provisions of section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212) shall apply to block grants under this title.

State Agency

Sec. 507. (a) Programs carried out with allotments made available to States under this title shall be administered by the State health agency, or the supervision of the administration of such programs shall be carried out by the State health agency; except that in the case of those States which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this title, as in effect on such date, by a State agency other than the State health agency, such State shall comply with the requirements of this subsection if it would otherwise comply but for the fact that such other agency administers, or supervises the administration of, any such programs providing services for crippled children.

(b) (1) Such State agency or agencies shall participate in the coordination of activities between programs carried out under this title and the early and periodic screening, diagnosis, and treatment program under title XIX, to ensure that such program is carried out without duplication of effort, and shall participate in the cooperative arrangements with the State agency carrying out such plan under title XIX as required in section 1902(a) (11) of this Act (relating to coordination of care and services available under this title and title XIX).

(2) Such State agency or agencies shall coordinate, or participate in the coordination of activities within the State with programs carried out under this title and related grant programs administered by the Secretary and other Federal agencies. Such programs include supplemental food programs for mothers, infants, and children administered by the Department of Agriculture, related education programs administered by the Department of Education, other health and developmental disability programs administered by the Secretary, and family planning services authorized under title XX of this Act.

TITLE X—GRANTS TO STATES FOR AID TO THE BLIND

Appropriation

Section 1001. For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals who are blind [and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care], there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the blind.

* * * * *

Payments to States

Sec. 1003. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

* * * * *

[(3) in the case of any State whose State plan approved under section 1002 meets the requirements of subsection (c)(1) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind to help them attain or retain capability for self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the blind, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the blind, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

[(C) one-half of the remainder of such expenditures.

The services referred to in subparagraph (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) prescribed by the Secretary, under conditions which shall be services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply

shall be determined in accordance with such methods and procedures as may be permitted by the Secretary ; and】

(3) *in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—*

(A) *75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision;*
plus

(B) *one-half of the remainder of such expenditures.*

【(4) in the case of any State whose State plan approved under section 1002 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.】

* * * * *

【(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1002 must provide that the State agency shall make available to applicants for or recipients of aid to the blind at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

【(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearings to the State agency administering or supervising the administration of such plan, that—

【(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

【(B) in the administration of the plan there is a failure to comply substantially with such provision,
the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.】

* * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

Part A—General Provisions

Definitions

Sec. 1101. (a) When used in this Act—

(1) The term “State”, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa and the Trust Territory of the Pacific Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term “States” when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. *Such term when used in title XX also includes the Virgin Islands, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.*

* * * * *

(9) The term “shared health facility” means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

and who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on a fee-for-service basis under titles [V, XVIII, and XIX] XVIII and XIX in an amount exceeding \$5,000 for any one month

during the preceding 12 months or in an aggregate amount exceeding \$40,000 during the preceding 12 months;
except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

* * * * *

Disclosure of Information in Possession of Department

Sec. 1106. (a) * * *

(c) *Notwithstanding sections 552 and 552a of title 5, United States Code, or any other provision of law, whenever the Secretary determines that a request for information is made in order to assist a party in interest (as defined in section 3 (14) of the Employee Retirement Income Security Act of 1974) with respect to the administration of an employee benefit plan (as defined in section 3 (3) of such Act), the Secretary may require the requester to pay the full cost, as determined by the Secretary, of providing such information, and any amounts so paid shall be deposited into the Federal Old-Age and Survivors Insurance Trust Fund.*

* * * * *

[Penalty for Fraud] Penalties

Sec. 1107. (a) * * *

(c) (1) *Any person who presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency, a claim (as defined in paragraph (10) (B)) that the Secretary determines is for a medical or other item or service—*

(A) *that such person knows or has reason to know was not provided as claimed, or*

(B) *that was provided while such person was barred from participation in the program under which such claim was made, pursuant to a determination by the Secretary under this section or section 1128, 1160, 1862 (d), or 1866,*

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$2,000 for each such item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

(2) *The Secretary shall not make a determination adverse to any person under paragraph (1) until such person has been given written notice and an opportunity for a hearing on the record at which he is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against him.*

(3) *In determining the amount of any penalty assessed pursuant to paragraph (1) of this subsection, the Secretary shall take into account*

(A) the nature of the claims and the circumstances under which they were presented, (B) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and (C) such other matters as justice may require.

(4) Any person adversely affected by a determination of the Secretary under this subsection may obtain a review of such determination in the United States Court of Appeals for the circuit in which such person resides, or in which the claim was presented, by filing in such court, within sixty days following notification to the person of the Secretary's final determination, a written petition requesting that the determination be modified or set aside. A copy of the petition shall be transmitted by the clerk of the court to the Secretary, and the Secretary shall then file in the court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been made before the Secretary shall be considered by the court, unless the failure or neglect to make such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reasons of additional evidence so taken and filed and he shall file such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

(5) Civil penalties and assessments imposed under this subsection may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered shall be paid to the Secretary, and disposed of as follows: (A) a portion of amounts recovered arising out of a claim under title XIX equal to the State's matching share of the amount paid by the State agency for such claim shall be paid to the State agency; (B) such portion of amounts recovered as is determined to have been paid out of

the trust funds under sections 1817 and 1841 shall be repaid to such trust funds; and (C) the remainder shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty has been assessed.

(6) A determination by the Secretary to assess a penalty under paragraph (1) of this subsection shall be final upon the expiration of the sixty-day period referred to in paragraph (4) unless the person against whom the penalty has been assessed files an appeal as provided in that paragraph. Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to paragraph (4) may not be raised as a defense to a civil action by the United States to collect a penalty or damages assessed under this subsection.

(7) The Secretary may refuse to make any further payment under title XVIII of this Act, or deny any further Federal financial participation under title XIX of this Act, for items or services furnished by any person with respect to whom a final determination has been made to assess a penalty under this subsection, for any item or service rendered during such period as the Secretary may deem appropriate. If the Secretary intends to exercise the authority in this subparagraph, he shall give written notice thereof to such person and to the State agency of each State which he has reason to believe does or may use the services of such person in providing medical assistance under a State plan approved under title XIX of this Act.

(8) Whenever the Secretary makes a final determination to impose a penalty under paragraph (1), he shall notify the appropriate State or local medical agency or organization, and appropriate Professional Standards Review Organization, and the appropriate State or local licensing agency or organization (including the agency specified in sections 1864(a) and 1902(a) (33)) that such a penalty has been imposed and the reasons therefor.

(9) The Secretary shall initiate a proceeding to determine whether to impose a civil penalty under paragraph (1) under this subsection only as authorized by the Attorney General pursuant to procedures agreed upon by them.

(10) For the purposes of this subsection—

(A) the term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act;

(B) the term "claim" means an application submitted by (i) a provider of services or other person, agency, or organization that furnishes services under title XVIII of this Act, or (ii) a person, agency, or organization which provides items or services under a State plan approved under title XIX of this Act, against the United States or a State agency for payment for health care services under title XVIII or a State plan approved under title XIX;

(C) the term "item or service" includes (i) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (ii)

in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim; and (D) the term "agency of the United States" includes any claims processing agent for a health insurance or medical services program under title XVIII or a State plan approved under title XIX.

Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam

Sec. 1108. [(a) Except as provided in 2002(a)(2)(C) the total amount certified by the Secretary of Health, Education, and Welfare under title I, X, XIV, and XVI, and under parts A and E of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—]

(a) The total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, and under part A of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

(1) for payment to Puerto Rico shall not exceed—

- (A) \$12,500,000 with respect to the fiscal year 1968,
- (B) \$15,000,000 with respect to the fiscal year 1969,
- (C) \$18,000,000 with respect to the fiscal year 1970,
- (D) \$21,000,000 with respect to the fiscal year 1971,
- (E) \$24,000,000 with respect to each of the fiscal years 1972 through 1978, or
- (F) \$72,000,000 with respect to the fiscal year 1979 and each fiscal year thereafter;

(2) for payment to the Virgin Islands shall not exceed—

- (A) \$425,000 with respect to the fiscal year 1968,
- (B) \$500,000 with respect to the fiscal year 1969,
- (C) \$600,000 with respect to the fiscal year 1970,
- (D) \$700,000 with respect to the fiscal year 1971,
- (E) \$800,000 with respect to each of the fiscal years 1972 through 1978, or
- (F) \$2,400,000 with respect to the fiscal year 1979 and each fiscal year thereafter;

(3) for payment to Guam shall not exceed—

- (A) \$575,000 with respect to the fiscal year 1968,
- (B) \$690,000 with respect to the fiscal year 1969,
- (C) \$825,000 with respect to the fiscal year 1970,
- (D) \$960,000 with respect to the fiscal year 1971,
- (E) \$1,100,000 with respect to each of the fiscal years 1972 through 1978, or
- (F) \$3,300,000 with respect to the fiscal year 1979 and each fiscal year thereafter;

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

- (1) for payment to Puerto Rico shall not exceed \$2,000,000,
 - (2) for payment to the Virgin Islands shall not exceed \$65,000,
- and

(3) for payment to Guam shall not exceed \$90,000.

[(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

[(1) for payment to Puerto Rico shall not exceed \$30,000,000,

[(2) for payment to the Virgin Islands shall not exceed \$1,000,000, and

[(3) for payment to Guam shall not exceed \$900,000.]

* * * * *

Demonstration Projects

Sec. 1115. (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, VI, X, XIV, XVI, *or* XIX [or XX], or part A of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 602, 1002, 1402, 1602, [1902, 2002, 2003, or 2004] *or* 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2) costs of such project which would not otherwise be included as expenditures under section 3, 403, 603, 1003, 1403, 1603, [1903, 2002] *or* 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, [or expenditures with respect to which payment shall be made under section 2002,] as may be appropriate.

* * * * *

Administrative and Judicial Review of Certain Administrative Determinations

Sec. 1116. (a) (1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, VI, X, XIV, XVI, [XIX, or XX] *or* XIX, or part A of title IV, he shall not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The

Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 604, 1004, 1404, 1604, [1904, or 2003] or 1904 may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, the judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(b) For the purposes of subsection (a), any amendment of a State plan approved under title I, VI, X, XIV, XVI, [XIX, or XX] or XIX, or part A of title IV, may, at the option of the State, be treated as the submission of a new State plan.

(c) Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title I, VI, X, XIV, XVI, [XIX, XX] or XIX or part A of title IV, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

Sec. 1117. [Repealed.]

Alternative Federal Payment With Respect to Public Assistance Expenditures

Sec. 1118. In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with September 30),

under paragraphs (1) and (2) of sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined by section 1905, instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, X, XIV, and XVI, and part A of title IV, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections. For purposes of the preceding sentence, the term "Federal medical assistance percentage" shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum, *and, in the case of all States, such percentage shall not be less than 50 per centum.*

* * * * *

Disclosure of Ownership and Related Information

Sec. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles **[V,] XVIII, [XIX, and XX]** *and XIX*, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under title **[V,] XVIII, [XIX, and XX]** *and XIX*, supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established **[pursuant to title V or]** under a State plan approved under title XIX; *or*

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX**;** *or***].**

[(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.]

* * * * *

Disclosure by Institutions, Organizations, and Agencies of Owners and Certain Other Individuals Who Have Been Convicted of Certain Offenses

Sec. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, [XIX, and XX] and XIX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.

* * * * *

Exclusion of Certain Individuals Convicted of Medicare- or Medicaid-Related Crimes

Sec. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2) (A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX [or title XX,] of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX [or title XX], where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

* * * * *

Coordinated Audits

Sec. 1129. (a) If an entity provides services reimbursable on a cost-related basis under title [V or] XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title [V or] XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title [V or] XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title [V or] XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the Sale incurred in the common audit) if it had participated in the common audit.

(b) (1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title [V, XVIII, or] XVIII or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

(3) The Secretary shall report to Congress not later than December 31, 1982, with respect to demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than December 31, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

Sec. 1130. (a) (1) (A) *Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the "Board"). The Board shall have five members, appointed by the Secretary without regard to the provisions*

of title 5, *United States Code*, governing appointments in the competitive service, who are knowledgeable with respect to hospital planning and hospital operations.

(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be appointed for shorter terms to permit staggered terms of office.

(C) Members of the Board shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS-18 under section 5332 of title 5, *United States Code*.

(D) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Board may need.

(2) The Board shall receive and act upon applications by hospitals, certified for participation (other than as "emergency hospitals") under titles XVIII and XIX, for transitional allowances.

(b) For purposes of this section—

(1) The term 'transitional allowance' means an amount which—

(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by titles V, XVIII, and XIX of this Act; and

(B) in accordance with this section, is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

(2) The term "qualified facility conversion" means closing, modifying, or changing the usage of an underutilized hospital facility which is expected to benefit the programs authorized under titles V, XVIII, and XIX by (A) eliminating excess bed capacity, (B) discontinuing an underutilized service for which there are adequate alternative sources, or (C) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.

(3) A hospital which has carried out a qualified facility conversion and which continues in operation will be regarded as having experienced a "reimbursement detriment"—

(A) to the extent that, solely because of the conversion, there is a reduction in that portion of the hospital's costs attributable to capital assets which are taken into account in determining reasonable cost for purposes of determining amount of payment to the hospital under title V, title XVIII, or a State plan approved under title XIX;

(B) if the conversion results, on an interim basis, in increased operating costs, to the extent that operating costs exceed amounts ordinarily reimbursable under title V, title XVIII, and the State plan approved under title XIX; or

(C) in the case of complete closure of a private nonprofit hospital, or local governmental hospital, other than for replacement of the hospital, to the extent of actual debt obligations previously recognized as reasonable for reimbursement, where the debt remains outstanding, less any salvage value.

(c) (1) *Any hospital may file an application with the Board (in such form and including such data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which is formally initiated after September 30, 1981. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursement detriment may be made prior to the actual conversion.*

(2) *The Board shall consider any application filed by a hospital, and if the Board finds that—*

(A) the facility conversion is a qualified facility conversion, and

(B) the hospital is experiencing or will experience a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under titles V and XVIII and the State plan approved under title XIX, for a period, not to exceed twenty years as specified by the Board, and, if the Board finds that the criteria in subparagraphs (A) and (B) are not met, it shall advise the Secretary not to establish a transitional allowance for that hospital. For an approved closure under subsection (b) (3) (C) the Board may recommend or the Secretary may approve, a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

(3) (A) *The Board shall notify a hospital of its findings and recommendations.*

(B) *A hospital dissatisfied with a recommendation may obtain an informal or formal hearing, at the discretion of the Secretary by filing (in the form and within a time period established by the Secretary) a request for a hearing.*

(4) (A) *Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing, the Secretary shall make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.*

(B) *The Secretary shall notify a hospital and any other appropriate parties of the determination.*

(C) *Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this Act, except that the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861(v) (1) of this Act, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1814(b) and 1833(a) (2) of this Act.*

(d) *In determining the reasonable cost incurred by a hospital with respect to which payment is authorized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.*

(e) (1) *The Secretary is authorized to establish transitional allowances only as provided in paragraphs (2) and (3).*

(2) *Prior to January 1, 1984, the Secretary is authorized to establish a transitional allowance for not more than fifty hospitals.*

(3) *On and after January 1, 1984, the Secretary is authorized to establish a transitional allowance for any hospital which qualifies for such an allowance under the provisions of this section.*

(4) *On or before January 1, 1983, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations.*

* * * * *

Period Within Which Certain Claims Must Be Filed

Sec. 1132. (a) Notwithstanding any other provision of this Act (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under title I, IV, **[V, X, XIV, XVI, XIX, or XX]** of this Act, or

(2) under any other provision of this Act which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this Act on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

* * * * *

Nonprofit Hospital Philanthropy

Sec. 1134. For purposes of determining, under titles **[V, XVIII, XVIII and XIX]** of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital which was made by a government entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a govern-

mental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

Part B—Professional Standards Review

* * * * *

Trial Period for Professional Standards Review Organizations

Sec. 1154. (a) * * *

(b) During any such trial period (which may not exceed 48 months except as provided in subsection (c)), the Secretary may require a Professional Standard Review Organization to perform, in addition to review of health care services) (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals [and to review of alcohol detoxification facility services], only such of the duties and functions as he requires the organization to perform under subsection (f) (2) or subsection (f) (4) and which the organization is capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the activities and functions required of that Professional Standards Review Organization under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

* * * * *

Duties and Functions of Professional Standards Review Organizations

Sec. 1155. (a) * * *

[(i) Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.]

* * * * *

Requirement of Review Approval as Condition of Payment of Claims

Sec. 1158. (a) Except as provided for in [subsections (d) and (e)] *subsection (d)* of this section and in sections 1159, 1861(v)(1)(G), and 1902(h), no Federal funds appropriated under any title of this Act (other than title V), for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

* * * * *

[(e) Subsection (a) of this section shall not apply to a determination by a Professional Standards Review Organization under section 1155(a)(1)(C) that detoxification services provided or proposed to be provided in a hospital on an inpatient basis could be more economically provided in a detoxification facility.]

* * * * *

Annual Reports

Sec. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

* * * * *

(4) the total costs incurred under titles [V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

* * * * *

TITLE XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS

Advance to State Unemployment Funds

Section 1201. (a)(1) Advances shall be made to the States from the Federal unemployment account in the Unemployment Trust Fund as provided in this section, and shall be repayable[, without interest,]

in the manner provided in sections 901(d)(1), 903(b)(2), and 1202. An advance to a State for the payment of compensation in any 3-month period may be made if—

(A) the Governor of the State applies therefor no earlier than the first day of the month preceding the first month of such 3-month period, and

(B) he furnishes to the Secretary of Labor his estimate of the amount of an advance which will be required by the State for the payment of compensation in each month of such 3-month period.

(2) In the case of any application for an advance under this section to any State for any 3-month period, the Secretary of Labor shall—

(A) determine the amount (if any) which he finds will be required by such State for the payment of compensation in each month of such 3-month period, and

(B) certify to the Secretary of the Treasury the amount (not greater than the amount estimated by the Governor of the State) determined under subparagraph (A).

The aggregate of the amounts certified by the Secretary of Labor with respect to any 3-month period shall not exceed the amount which the Secretary of the Treasury reports to the Secretary of Labor is available in the Federal unemployment account for advances with respect to each month of such 3-month period.

(3) For purposes of this subsection—

(A) an application for an advance shall be made on such forms, and shall contain such information and data (fiscal and otherwise) concerning the operation and administration of the State unemployment compensation law, as the Secretary of Labor deems necessary or relevant to the performance of his duties under this title,

(B) the amount required by any State for the payment of compensation in any month shall be determined with due allowance for contingencies and taking into account all other amounts that will be available in the State's unemployment fund for the payment of compensation in such month, and

(C) the term "compensation" means cash benefits payable to individuals with respect to their unemployment, exclusive of expenses of administration.

(b) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, transfer in monthly installments from the Federal unemployment account to the account of the State in the Unemployment Trust Fund the amount certified under subsection (a) by the Secretary of Labor (but not exceeding that portion of the balance in the Federal unemployment account at the time of the transfer which is not restricted as to use pursuant to section 903(b)(1)). The amount of any monthly installment so transferred shall not exceed the amount estimated by the State to be required for the payment of compensation for the month with respect to which such installment is made.

Repayment by States of Advances to State Unemployment Funds

Sec. 1202. (a) The Governor of any State may at any time request that funds be transferred from the account of such State to the Federal unemployment account in repayment of part or all of that balance of advances, made to such State under section 1201, specified in the request. The Secretary of Labor shall certify to the Secretary of the Treasury the amount and balance specified in the request; and the Secretary of the Treasury shall promptly transfer such amount in reduction of such balance.

(b) (1) *Any advance made to a State under section 1201 shall be repaid at a rate of interest equal to 10 percent, compounded quarterly; except that such interest shall be waived if—*

(A) such advance is fully repaid from the State's unemployment fund before the end of the Federal fiscal year in which it was made; and

(B) the Secretary of Labor certifies on September 1 of the fiscal year in which such advance is made that such State's unemployment fund has reserves and income which are adequate to meet the needs of such State for payment of compensation during the 6-month period beginning on October 1 of the Federal fiscal year following the fiscal year in which such advance is made.

(2) *Interest required by reason of paragraph (1) may not be paid, directly or indirectly, by a State from amounts in its unemployment fund. If the Secretary of Labor determines that any State action results in the paying of such interest directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) from such unemployment fund, the Secretary of Labor shall not certify such State's unemployment compensation law under section 3304 of the Internal Revenue Code of 1954. Such noncertification shall be made in accordance with section 3304(c) of such Code.*

(3) (A) *Except as provided under subparagraphs (B) and (C), interest required by reason of paragraph (1) shall be paid on a quarterly basis as the Secretary of the Treasury determines it to be due and shall be paid so as to be received prior to the last day of the quarter for which it is due. Such interest shall be paid as a repayment to an offsetting receipt account established within the Treasury.*

(B) For the fiscal year in which an advance is made, any interest required by reason of paragraph (1) shall be paid so as to be received prior to the last day of such fiscal year.

(C) Interest required by reason of paragraph (1) on an advance made prior to October 1, 1981, shall be paid at such time after October 1, 1981, as the Secretary of the Treasury determines to be appropriate.

(c) (1) *For purposes of determining whether an advance is fully repaid within the fiscal year in which it was made, as determined for purposes of subsection (b) (1) (A), repayments of such advances shall be applied first to the balance of such advances made in the same fiscal year as such repayment.*

(2) *Except as otherwise provided in paragraph (1), notwithstanding any other provision of this title or title IX, for purposes of determining unpaid loan principal, any repayments of advances under this title, including reductions in such advances by reason of credit reductions under section 3302 of the Internal Revenue Code of 1954, shall be applied so as to reduce the balance of such advances which has been longest outstanding.*

* * * * *

TITLE XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

Appropriation

Section 1401. For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals eighteen years of age and older who are permanently and totally disabled [and of encouraging each State, as far as practicable under such conditions, to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care], there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the permanently and totally disabled.

* * * * *

Payments to States

Sec. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

* * * * *

[(3) in the case of any State whose State plan approved under section 1402 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled to help them attain or retain capability of self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided

in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid to the permanently and totally disabled, if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services provided (in accordance with the next sentence) to applicants for or recipients of aid to the permanently and totally disabled, and to individuals requesting such services who within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

[(C) one-half of the remainder of such expenditures.

The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) Under conditions which shall be prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such

State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and】

(3) *in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—*

(A) *75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivisions; plus*

(B) *one-half of the remainder of such expenditures.*

【(4) in the case of any State whose State plan approved under section 1402 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (3) and provided in accordance with the provisions of such paragraph.】

【(c) (1) In order for a State to qualify for payments under paragraph (3) of subsection (a), its State plan approved under section 1402 must provide that the State agency shall make available to applicants for or recipients of aid to the permanently and totally disabled at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

【(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, that—

【(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

【(B) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (3) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (3) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (4) of such subsection.】

* * * * *

TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED, OR FOR SUCH AID AND MEDICAL ASSISTANCE FOR THE AGED

Appropriation

Section 1601. For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, *and* (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of individuals who are 65 years of age or over and who are not recipients of aid to the aged, blind, or disabled but whose income and resources are insufficient to meet the costs of necessary medical services, [and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-support or self-care,] there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged.

* * * * *

Payments to States

Sec. 1603. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

* * * * *

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan (including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

(B) the larger of the following amounts: (i) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (I) the product of \$45 multiplied by the total number

of such recipients of aid to the aged, blind, or disabled for such month, or (II) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of \$37.50 multiplied by the total number of such recipients, or (ii) 15 per centum of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of any expenditure with respect to any month as exceeds the product of \$7.50 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month; *and*

(3) in the case of any State, an amount equal to the Federal medical percentage (as defined in section 61(c) of the total amounts expended during such quarter as medical assistance for the aged under the State plan (including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof) ; and

[(4) in the case of any State whose State plan approved under section 1602 meets the requirements of subsection (c)(1), an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

[(A) 75 per centum of so much of such expenditures as are for—

[(i) services which are prescribed pursuant to subsection (c)(1) and are provided (in accordance with the next sentence) to applicants for or recipients of aid or assistance under the plan to help them attain or retain capability for self-support or self-care, or

[(ii) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to such applicants or recipients, or

[(iii) any of the services prescribed pursuant to subsection (c)(1), and of the services specified as provided in clause (ii), which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid or assistance under the plan if such services are requested by such individuals and are provided to such individuals in accordance with the next sentence, or

[(iv) the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivisions; plus

[(B) one-half of so much of such expenditures (not included under subparagraph (A)) as are for services pro-

vided (in accordance with the next sentence) to applicants for or recipients of aid or assistance under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid or assistance;

[(C) one-half of the remainder of such expenditures. The services referred to in subparagraphs (A) and (B) shall, except to the extent specified by the Secretary, include only—

[(D) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (E), if provided by such staff, and

[(E) under conditions which shall be prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (D) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved. The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraphs (B) and (C) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary; and]

(4) *in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—*

(A) *75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institu-*

tions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) one-half of the remainder of such expenditures.

[(5) in the case of any State whose State plan approved under section 1602 does not meet the requirements of subsection (c) (1), an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan, including services referred to in paragraph (4) and provided in accordance with the provisions of such paragraph.】

* * * * *

[(c) (1) In order for a State to qualify for payments under paragraph (4) of subsection (a), its State plan approved under section 1602 must provide that the State agency shall make available to applicants for or recipients of aid to the aged, blind, or disabled under such State plan at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary.

[(2) In the case of any State whose State plan included a provision meeting the requirements of paragraph (1), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency, administering or supervising the administration of such plan, that—

[(A) the provision has been so changed that it no longer complies with the requirements of paragraph (1), or

[(B) in the administration of the plan there is a failure to comply substantially with such provision, the Secretary shall notify such State agency that further payments will not be made to the State under paragraph (4) of subsection (a) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied further payments with respect to the administration of such State plan shall not be made under paragraph (4) of subsection (a) but shall instead be made, subject to the other provisions of this title, under paragraph (5) of such subsection.】

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TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * *

Part A—Determination of Benefits

Eligibility for and Amount of Benefits

Sec. 1611. * * *

Period for Determination of Benefits

[(c) (1) An individual's eligibility for benefits under this title and the amount of such benefits shall be determined for each quarter of a calendar year except that, if the initial application for benefits is filed

in the second or third month of a calendar quarter, such determinations shall be made for each month in such quarter. Eligibility for and the amount of such benefits for any quarter shall be redetermined at such time or times as may be provided by the Secretary.

[(2) For purposes of this subsection an application shall be considered to be effective as of the first day of the month in which it was actually filed.]

(c) (1) *An individual's eligibility for a benefit under this title for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraph (2), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.*

(2) *The amount of such benefit for the month in which application for such benefits is filed or, if the Secretary so determines, for such month and the following month, and for any month following a month of ineligibility for such benefits (or, if the Secretary so determines, such month and the following month) shall be determined on the basis of the individual's (and eligible spouse's, if any) income and other relevant circumstances in such month.*

(3) *For purposes of this subsection, an application shall be effective as of the first day of the month in which it is filed.*

(4) *The Secretary may waive the limitations specified in subparagraphs (A) and (B) of subsection (e) (1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Secretary shall apply, to the month preceding the month of removal, or, if the Secretary so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.*

* * * * *

Income

Sec. 1612. * * *

Exclusions From Income

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded—

* * * * *

(3) (A) the total unearned income of such individual (and such spouse, if any) in a [calendar quarter] month which, as determined in accordance with criteria prescribed by the Secretary, is received too infrequently or irregularly to be included, if such income so received does not exceed [\$60] \$20 in such [quarter] month, and (B) the total earned income of such individual (and such spouse, if any) in a [calendar quarter] month which, as de-

terminated in accordance with such criteria, is received too infrequently or irregularly to be included, if such income so received does not exceed **[\$30]** \$10 in such **[quarter]** month;

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Rehabilitation Services for Blind and Disabled Individuals

Sec. 1615. (a) In the case of any blind or disabled individual who—

(1) *has attained age 16 but has not attained age 65, and*

(2) *is receiving benefits (or with respect to whom benefits are paid) under this title,*

the Secretary shall make provision for referral of such individual to the appropriate State agency administering the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act, **[or, in the case of any such individual who has not attained age 16, to the appropriate State agency administering the State plan under subsection (b) of this section,]** and (except in such cases as he may determine) for a review not less often than quarterly of such individual's blindness or disability and his need for and utilization of the services made available to him under such plan.

[(b) (1) The Secretary shall by regulation prescribe criteria for approval of State plans for—

[(A) assuring appropriate counseling for disabled children referred pursuant to subsection (a) and their families,

[(B) establishment of individual service plans for such disabled children, and prompt referral to appropriate medical, educational, and social services,

[(C) monitoring to assure adherence to such service plans, and

[(D) provision for such disabled children who are 6 years of age and under, or who have never attended public school and require preparation to take advantage of public educational services, of medical, social, developmental, and rehabilitative services, in cases where such services reasonably promise to enhance the child's ability to benefit from subsequent education or training, or otherwise to enhance his opportunities for self-sufficiency or self-support as an adult.

[(2) Such criteria shall include—

[(A) administration—

[(i) by the agency administering the State plan for crippled children's services under title V of this Act, or

[(ii) by another agency which administers programs providing services to disabled children and which the Governor of the State concerned has determined is capable of administering the State plan described in the first sentence of this subsection in a more efficient and effective manner than the agency described in clause (i) (with the reasons for such determination being set forth in the State plan described in the first sentence of this subsection) ;

[(B) coordination with other agencies serving disabled children: and

[(C) establishment of an identifiable unit within such agency which shall be responsible for carrying out the plan.]

[(c) Every individual age 16 or over with respect to who the Secretary is required to make provision for referral under subsection (a) shall accept such services as are made available to him under the State plan for vocational and rehabilitation services approved under the Vocational Rehabilitation Act; and no such individual shall be an eligible individual or eligible spouse for purposes of this title if he refuses without good cause to accept services for which he is referred under subsection (a).]

[(d) The Secretary is authorized to pay to the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act the costs incurred under such plan in the provision of rehabilitation services to individuals referred for such services pursuant to subsection (a).]

[(e) (1) The Secretary shall, subject to the limitations imposed by paragraphs (2) and (3), pay to the State agency administering a State plan of a State under subsection (b) of this section, the costs incurred each fiscal year which begins after September 30, 1976, and ends prior to October 1, 1982, in carrying out the State plan approved pursuant to such subsection (b).]

[(2) (A) Of the funds paid by the Secretary with respect to costs, incurred in any State, to which paragraph (1) applies, not more than 10 per centum thereof shall be paid with respect to costs incurred with respect to activities described in subsection (b) (1) (A), (B), and (C).]

[(B) Whenever there are provided pursuant to this section to any child services of a type which is appropriate for children who are not blind or disabled, there shall be disregarded for purposes of computing any payment with respect thereto under this subsection, so much of the costs of such services as would have been incurred if the child involved had not been blind or disabled.]

[(C) The total amount payable under this subsection for any fiscal year, with respect to services provided in any State, shall be reduced by the amount by which the sum of the public funds expended (as determined by the Secretary) from non-Federal sources for services of the type involved for such fiscal year is less than the sum of such funds expended from such sources for services of such type for the fiscal year ending June 30, 1976.]

[(3) No payment under this subsection with respect to costs incurred in providing services in any State for any fiscal year shall exceed an amount which bears the same ratio to \$30,000,000 as the under age 7 population of such State (and for purposes of this section the District of Columbia shall be regarded as a State) bears to the under age 7 population of the fifty States and the District of Columbia. The Secretary shall promulgate the limitation applicable to each State for each fiscal year under this paragraph on the basis of the most recent satisfactory data available from the Department of Commerce not later than 90 nor earlier than 270 days before the beginning of such year.]

Optional State Supplementation

Sec. 1616. * * *

(e) (1) Each State shall establish or designate one or more State or local authorities which shall establish, maintain, and insure the

enforcement of standards for any category of institutions, foster homes, or group living arrangements in which (as determined by the State) a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights.

(2) Each State shall annually make available for public review [, as a part of the services program planning procedures established pursuant to section 2004 of this Act,] a summary of the standards established pursuant to paragraph (1), and shall make available to any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

* * * * *

Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment

Sec. 1619. (a) Any individual who is an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611(b) or under this section for the month preceding the month for which eligibility for benefits under this section is now being determined, and who would otherwise be denied benefits by reason of section 1611(e) (4) or ceases to be an eligible individual (or eligible spouse) because his earnings have demonstrated a capacity to engage in substantial gainful activity, shall nevertheless qualify for a monthly benefit equal to an amount determined under section 1611(b) (1) (or, in the case of an individual who has an eligible spouse, under section 1611(b) (2)), and for purposes of [titles XIX and XX] *title XIX* of this Act shall be considered a disabled individual receiving supplemental security income benefits under this title, for so long as the Secretary determines that—

(1) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability, and continues to meet all non-disability-related requirements for eligibility for benefits under this title; and

(2) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments).

(b) For purposes of [titles XIX and XX] *title XIX*, any individual under age 65 who, for the month preceding the first month in the period to which this subsection applies, received—

(i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability,

(ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis,

(iii) a payment of monthly benefits under subsection (a), or

(iv) a supplementary payment under section 1616(c) (3), shall be considered to be a blind or disabled individual receiving supplemental security income benefits for so long as the Secretary determines under regulations that—

(1) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under this title;

(2) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments);

(3) the termination of eligibility for benefits under title XIX [or XX] would seriously inhibit his ability to continue his employment; and

(4) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this title and [titles XIX and XX] *title XIX* which would be available to him in the absence of such earnings.

Medical and Social Services for Certain Handicapped Persons

Sec. 1620. * * *

(c) In order to participate in the pilot program and be eligible to receive payments for any period under subsection (d), a State (during such period) must have a plan, approved by the Secretary as meeting the requirements of this section, which provides medical and social services for severely handicapped individuals whose earnings are above the level which ordinarily demonstrates an ability to engage in substantial gainful activity and who are not receiving benefits under section 1611 or 1619 or assistance under a State plan approved under section 1902, and which—

(1) declares the intent of the State to participate in the pilot program;

(2) designates an appropriate State agency to administer or supervise the administration of the program in the State;

(3) describes the criteria to be applied by the State in determining the eligibility of any individual for assistance under the plan and in any event requires a determination by the State agency to the effect that (A) such individual's ability to continue his employment would be significantly inhibited without such assistance and (B) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him under this title and titles XIX and XX in the absence of those earnings;

(4) describes the process by which the eligibility of individuals for such assistance is to be determined (and such process may not involve the performance of functions by any State agency or entity which is engaged in making determinations of disability for purposes of disability insurance or supplemental security in-

come benefits' except when the use of a different agency or entity to perform those functions would not be feasible);

(5) describes the medical and social services to be provided under the plan;

(6) describes the manner in which the medical and social services involved are to be provided and, if they are not to be provided through the State's medical assistance and social services programs under titles XIX and XX (with the Federal payments being made under subsection (d) of this section rather than under those titles), specifies the particular mechanisms and procedures to be used in providing such services; and

(7) contains such other provisions as the Secretary may find to be necessary or appropriate to meet the requirements of this section or otherwise carry out its purpose.

[The plan under this section may be developed and submitted as a separate State plan, or may be submitted in the form of an amendment to the State's plan under section 2003(d)(1).]

* * * * *

BENEFITS FOR INDIVIDUALS FORMERLY RECEIVING MINIMUM BENEFITS UNDER TITLE II

Sec. 1622. (a) *Any individual who—*

(1) *is 60 years of age or older but has not attained the age of 65;*

(2) *would be an eligible individual or eligible spouse under section 1611 if such individual were 65 years of age;*

(3) *is not otherwise eligible for a benefit under section 1611;*

(4) *for the month of July 1981 was entitled to a monthly benefit under title II of this Act for which he made application prior to August 1, 1981, as determined without regard to any deductions on account of work required by section 203, which entitlement amount (as so determined) was reduced for any month by reason of the amendments made by section 02 of the Omnibus Reconciliation Act of 1981 (relating to the elimination of the minimum benefit); and*

(5) *is not entitled under title II to a monthly benefit, as determined without regard to any deductions on account of work required by section 203, in an amount equal to or greater than such entitlement amount (as so determined) for July 1981;*

shall be eligible for a benefit for each month in which he meets the requirements of this subsection in an amount determined under subsection (b) or (c).

(b) *The amount of the monthly benefit payable under subsection (a) shall be the amount of the monthly benefit which would otherwise be payable to such individual under this title if he were 65 years of age; except that—*

(1) *the amount of such monthly benefit shall not exceed—*

(A) *in the case of an individual described in subsection (a) who does not have an eligible spouse, an amount equal to the amount by which such individual's monthly benefit entitlement under title II for such month as determined without regard to any deductions on account of work required by section 203, is less than the amount of such individual's*

monthly benefit entitlement under title II for July 1981 (as so determined); or

(B) in the case of an individual and his spouse, both of whom are individuals described in subsection (a), an amount equal to the amount by which the combined amount of their monthly benefit entitlements under title II of such month (as so determined), is less than the combined amount of their monthly benefit entitlements under title II for July 1981 (as so determined);

(2) the benefit amount shall be determined on the basis of the dollar amounts applicable under this title for July 1981 (without regard to cost-of-living adjustments made after July 1981 under section 1617) in the case of any individuals described in paragraph (1); and

(3) in the case of an individual described in subsection (a) who has a spouse eligible for benefits under this title, other than by reason of this section, the amount of such monthly benefit for such individual (described in subsection (a)) shall be determined under subsection (c), and the amount of the monthly benefit for such spouse shall be determined in the same manner as for an individual who does not have an eligible spouse.

(c) The amount of the monthly benefit for an individual described in subsection (b) (3) shall be an amount equal to the amount by which—

(1) the monthly benefit amount for which such individual and his spouse would be eligible for such month under this title if both he and his spouse were 65 years of age, determined on the basis of the dollar amounts applicable under this title for July 1981 (without regard to cost-of-living adjustments made after July 1981 under section 1617); exceeds

(2) the monthly benefit amount under this title for which his spouse is eligible for such month;

except that the amount of such monthly benefit shall not exceed the amount by which such individual's monthly benefit entitlement under title II for such month, as determined without regard to deductions on account of work under section 203, is less than his monthly benefit entitlement under title II (as so determined) for July 1981.

(d) An individual who is entitled to a benefit under this section shall not be considered to be an individual receiving supplemental security income benefits under this title for purposes of section 1616 of this title or of any provision of law other than this title.

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d) (2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; *and*

(3) home health services [; and].

[(4) alcohol detoxification facility services.]

* * * * *

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) * * *

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

* * * * *

(D) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical [; occupational,] or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; *or*

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status [or because of the severity of the dental procedure], require hospitalization in connection with the provision of such services; [or]

[(F) in the case of alcohol detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification) ;]

* * * * *

Payment of Benefits

Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of

each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a) (1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b) (3) (ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a) (4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (h) of this section), (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b) (3) (B) (ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services, and (G) with respect to expenses incurred for services described in subsection (i) (3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, [and (H) with respect to items and services

described in section 1861(s) (10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and (2) in the case of services described in section 1832(a) (2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1881)—

(A) with respect to home health services and to items and services described in section 1861(s) (10), the reasonable cost of such services, as determined under section 1861(v) ;

(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a) (2) (A), but in no case may the payment for such other services exceed 80 percent of such costs ;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services.

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a) (2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v) (1) (A), less the amount a provider may charge as described in clause (ii) of section 1866(a) (2) (A), but in no case may the payment for such services (other than for items and services described in section 1861(s) (10)) exceed 80 percent of such costs ;

(4) in the case of facility services described in subparagraph (F) of section 1832(a) (2), the applicable amount described in paragraph (2) of section 1833(i) ; and

(5) in the case of preadmission diagnostic services described in section 1861(s) (2) (C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$60 \$75 ; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year. (2) (1) such total amount shall not include expenses incurred (A) for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the

Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, [or (B) for items and services described in section 1861(s)(10).] [(3)] (2) such deductible shall not apply with respect to home health services, and [(4)] (3) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * *

Procedure for Payment of Claims of Providers of Services

Sec. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861 (m)(7) and needed skilled nursing

care on an intermittent basis, or physical[, occupational,] or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * *

Enrollment Periods

Sec. 1837. * * *

[(e) There shall be a general enrollment period which is any period after the period described in subsection (d).]

(e) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Any individual—

(1) who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839[(e)](c) and upon attainment of age 65;

(2) (A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of [the month in which the individual files an application establish-

ing such entitlement], *the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)*

Coverage Period

Sec. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

* * * * *

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, [the first day of the third month] *the July 1* following the month in which he so enrolls; or

* * * * *

Amounts of Premiums

[Sec. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be \$3.

[(b) (1) The monthly premium of each individual enrolled under this part for each month after 1967 and before July 1, 1973, shall be the amount determined under paragraph (2).]

[(2) The Secretary shall, during December 1968 and of each year ending on or before December 31, 1971, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 in each succeeding year. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such 12-month period will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for such 12-month period. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin. Whenever the Secretary, pursuant to the preceding sentence, promulgates the dollar amount which shall be applicable for premiums for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of premiums so promulgated.

[(c) (1) The Secretary shall, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such 12-month period. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.]

[(2) The monthly premium of each individual enrolled under this part for each month after June 1973 shall, except as provided in subsection (d), be the amount determined under paragraph (3).

[(3) The Secretary shall, during December of 1972 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium shall be equal to the smaller of—

[(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that 12-month period, or

[(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of \$900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on May 1 of the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals on the following May 1.

[Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

[(+) The Secretary shall also, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred in the Federal Supplementary Medical Insurance Trust Fund for such 12-month period with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.]

Sec. 1839. (a) (1) *The Secretary shall, during December of 1981 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium for all enrollees shall be equal to the amount specified in paragraph (2).*

(2) *The Secretary shall, during December of 1981 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the ag-*

gregate amount for such 12-month period with respect to those enrollees age 65 and over will equal 24 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services provided to such enrollees and related administrative costs incurred in such 12-month period. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (2) and the derivation of the dollar amounts specified in such paragraph.

(4) The Secretary shall also, during December of 1981 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 for informational purposes. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to disabled enrollees under age 65 will equal 24 percent of the total of the benefits and administrative costs which he estimates will be incurred in the Federal Supplementary Medical Insurance Trust Fund for such 12-month period with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

[(d)] (b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and [the month after the month] the close of the enrollment period in which he reenrolled. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

[(e)] (c) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

[(f)] (d) For purposes of subsection [(c)] (b) (and section 1837 (g) (1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which

he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

* * * * *

Use of Carriers for Administration of Benefits

Sec. 1842. * * *

(b) (1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title; and the requirement of subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health and Human Services perform-

ing functions under this title and acting within the scope of his or its authority, and the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year) ;

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is \$100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy ;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part ;

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part ; and

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year ;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. [In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

[No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of

each year) in which the service is rendered. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on July 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.】

(4) (A) *In determining the reasonable charge for services for purposes of paragraph (3), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.*

(B) (i) *Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last calendar year ending prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.*

(ii) *In the case of physician services, the prevailing charge level determined for purposes of clause (i) (II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. For any twelve-month period beginning on July 1 of any year (beginning with 1982), no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (D)) for that service.*

(iii) *Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.*

(C) *In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable, may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s) (6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.*

(D) *The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 50 percent of the customary charges made for similar services in the State during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In States with more than one carrier, the statewide prevailing charge level shall be the weighted average of the fiftieth percentiles of the customary charges of each carrier.*

(E) *Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—*

(i) *the service or procedure is performed in an area which the Secretary has designated as a physician shortage area, taking into account the criteria used in making the designation of a rural health clinic under divisions (I) and (II) of section 1861(aa)*

(2) (i),

(ii) *the physician has a regular practice in the physician shortage area,*

(iii) *the charge does not exceed the prevailing charge level as determined under subparagraph (B), and*

(iv) *the charge does not exceed the amount generally charged by such physician for similar services.*

(F) *The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861 (v) (1) (K).*

[(4)] (5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] (6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.¹

* * * * *

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. * * *

(i) *Coverage extended to additional groups of individuals under an agreement (or modification of an agreement) requested by a State during 1981 shall not extend to items and services furnished under this part after the second month beginning after the date of the enactment of this subsection.*

* * * * *

Part C—Miscellaneous Provisions

Definition of Services, Institutions, Etc.

Sec. 1861. For purposes of this title—

* * * * *

Medical and Other Health Services

(s) The term “medical and other health services” means any of the following items or services:

* * * * *

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; *and*

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient’s physical condition[; and].

[(10) pneumococcal vaccine and its administration.]

No diagnostic tests performed in any laboratory which is independent of a physician’s office, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

[(11)] (10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(12)] (11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

[(13)] (12) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

[(14)] (13) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

* * * * *

Provider of Services

(u) The term "provider of services" means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [detoxification facility,] or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v) (1) * * *

(G) (i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title, except that if the Secretary determines that [the hospital had (during the immediately preceding calendar year) and average daily occupancy rate of 80 percent or more], *there is not an excess of hospital beds in such hospital or in the area of such hospital which could be converted for use in providing extended care services* such payment shall be made (during such period) on the basis of the reasonable cost of inpatient hospital services.

[(iv) For the purpose of determining the occupancy rate with respect to hospitals under clause (i)—

(I) public hospital under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(II) beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subparagraph or section 1902(h).]

* * * * *

(J) Such regulations shall provide that an inpatient routine nursing salary cost differential shall be allowable as a reimbursable cost of hospitals, at a rate not to exceed 4.5 percent, to be applied in the same manner as the nursing salary cost differential was applied to such costs for the month of April 1981.

(K) The Secretary shall issue regulations that provide for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals, community health centers, or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the reasonable charges in the same area for similar services provided in physicians offices.

* * * * *

Arrangements for Certain Services

(w) (1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title [V or] XIX, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.

* * * * *

Rural Health Clinic Services

(aa) (1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s) (2) (A) if furnished as an incident to a physician's professional service [and items and services described in section 1861(s) (10)],

* * * * *

[Alcohol Detoxification Facility Services

[(bb) (1) The term "alcohol detoxification facility services" means services provided by a detoxification facility in order to reduce or eliminate the amount of alcohol in the body, but only to the extent

that such services would be covered under subsection (b) if furnished as inpatient services by a hospital, or are physicians' services covered under subsection (s).

[(2) The term "detoxification facility" means a public or voluntary community-based nonprofit facility, other than a hospital, which—

[(A) is engaged in furnishing or inpatients the services described in paragraph (1);

[(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

[(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

[(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.]

* * * * *

Exclusions From Coverage

Sec. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member [, or, in the case of items and services described in section 1861(s) (10), which are not reasonable and necessary for the prevention of illness];

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations [(except as otherwise allowed under section 1861(s) (10) and paragraph (1))];

* * * * *

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, [or because of the severity of the dental procedure.] requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, or calluses, the trimming of nails, and other routine hygienic care).

(b) (1) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan, policy, or insurance. The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

(2) (A) *In the case of an individual who is entitled to benefits under part A or is eligible to enroll under part B solely by reason of section 226A, payment under this title may not be made with respect to any item or service furnished during the period described in subparagraph (B) to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made (as determined in accordance with regulations) under any other insurance policy or plan.*

(B) *The provisions of subparagraph (A) shall apply to an individual only during the 12-month period which begins with the earlier of—*

(i) the month in which a regular course of renal dialysis is initiated, or

(ii) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under this title (if he had filed an application for such benefits) under the provisions of section 226(b) (1) (B).

(C) *Where payment for an item or service under such policy or plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—*

(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such insurance policy or health benefit plan; and

(ii) such payment under this title, when combined with the amount payable under such policy or plan, may not exceed the combined amount which would have been payable under this title and such policy or plan if this paragraph were not in effect.

(3) (A) *Payment may not be made under this title to or on behalf of any individual with respect to any item or service to the extent that payment for such item or service has been made, or can reasonably be*

expected to be made (as determined in accordance with regulations), under any health benefits plan in which such individual or a member of his family is enrolled under the provisions of chapter 89 of title 5, United States Code.

(B) Where payment for an item or service under such a plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such a plan; and

(ii) such payment under this title, when combined with the amount payable under such a plan, may not exceed the combined amount which would have been payable under this title and such plan if this paragraph were not in effect.

(C) Notwithstanding subparagraphs (A) and (B), payment shall be made under this title as if such subparagraphs were not in effect if the Secretary enters into an agreement with the Director of the Office of Personnel Management which provides that payments shall be made by the Director to the Secretary, to be deposited into the appropriate trust fund, within 30 days after payment has been made under this title with respect to those items and services described in subparagraph (A), in an amount determined under subparagraphs (D) and (E).

(D) With respect to payments made under part A of this title relating to items and services described in subparagraph (A), the amount of the payment by the Director shall be equal to—

(i) the amount which would be paid under part A of this title with respect to such items and services if subparagraphs (A) and (B) were not in effect, multiplied by

(ii) a fraction, the numerator of which is the amount described in clause (i) less the amount which would have been paid under part A with respect to such items and services in accordance with the provisions of subparagraphs (A) and (B), and the denominator of which is the amount described in clause (i).

Amounts paid by the Director under this subparagraph shall be deposited into the Federal Hospital Insurance Trust Fund.

(E) With respect to payments made under part B of this title relating to items and services described in subparagraph (A), the amount of the payment by the Director shall be equal to—

(i) the amount which would be paid under part B of this title with respect to such items and services if subparagraphs (A) and (B) were not in effect, multiplied by

(ii) a fraction, the numerator of which is the amount described in clause (i) less the amount which would have been paid under part B with respect to such items and services in accordance with the provisions of subparagraphs (A) and (B), and the denominator of which is the amount described in clause (i).

Amounts paid by the Director under this subparagraph shall be deposited into the Federal Supplementary Medical Insurance Trust Fund.

(F) For purposes of subparagraphs (D) (ii) and (E) (ii), the Director and the Secretary shall jointly determine the fraction described

in such subparagraphs on an annual basis with respect to all health benefits plans referred to in subparagraph (A), based upon the average aggregate amount which would have been paid under part A or B (as the case may be) for such items and services in accordance with subparagraphs (A) and (B) in the case of all such plans.

* * * * *

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa) (2) or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc) (2), or whether a laboratory meets the requirements of paragraphs [(11) and (12)] (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p) (4), or whether an ambulatory surgical center meets the standards specified under section 1832(a) (2) (F) (i). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization.

* * * * *

Agreements With Providers of Services

Sec. 1866. (a) (1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

* * * * *

[An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.]

(2) (A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a) (1) or (a) (3), section 1833(b), or section 1861(y) (3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section.

[A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s) (10) for which payment is made under part B.]

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

State Plans for Medical Assistance

Sec. 1902. (a) ***

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the

State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI *or who is an individual specified in subsection (1); and*

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); ~~and~~

~~[(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—~~

~~(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and~~

~~(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;]~~

(C) that if medical assistance is included for any group of individuals described in section 1905(a), other than individuals described in subparagraph (A), then the plan shall include a description with respect to each such group of the criteria for determining eligibility for, and the extent of, such medical assistance;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, and (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals. ~~and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals~~

approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A) ;

* * * * *

(13) provide—

(A) [(i) for the inclusion of some institutional and some noninstitutional care and services, and]

[(ii)] for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, [and]

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), and

[(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and]

[(D) (i) for payment (except where the State agency is subject to an order under section 1914) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section, and (ii) for payment of the reasonable cost of

inappropriate inpatient services (described in subsection (h) (1)) for which payment is provided only because of subsection (h) at the rate of payment for such services provided for under such subsection.】

【(E)】 (C) for payment (except where the State agency is subject to an order under section 1914) of the *hospital* skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by 【each skilled nursing or intermediate care facility】 *each hospital, skilled nursing facility, and intermediate care facility* and periodic audits by the State of such reports; *except that the rate established by the State for payment for services provided by hospitals under the plan must be established at a level such that the aggregate of the payments made under such plan for each fiscal year to hospitals shall not exceed the aggregate amount of such payments for such fiscal year which would be made for provision of the same services if reimbursement were on a reasonable cost basis as determined under section 1861(v) for purposes of title XVIII*

【(F)】 (D) for payment for services described in section 1905(a) (2) (B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a) (3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

* * * * *

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institutions, and that there will be a periodical determination of his need for continued treatment in the institution; *and*

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii), section 603(a)(1)(A)(i) and (ii), or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; **[and]**

[D) provide methods of determining the reasonable cost of institutional care for such patients;]

* * * * *

[(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;]

(23) provide that limitations or restrictions elected by a State with respect to choice by recipients of medical assistance provided for by the State—

(A) must be cost-effective arrangements which provide for reasonable payment based upon comparison of costs at which services of proper quality may be obtained and are actually available (and for this purpose the plan may provide that such arrangements need not be in effect in all political subdivisions of the State notwithstanding the provisions of paragraph (1); and

(B) must assure that such recipients shall have reasonable access to services (taking into account geographic location and reasonable traveltime) for which they are eligible (including emergency services and provision for timely referral and transfer to other providers when medically appropriate) through providers which meet all applicable standards under the State plan and whose services are available to such recipients;

* * * * *

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

【(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or】

(2) any age requirements which excludes any individual who has not attained the age of 19 and is a dependent child under part A of title IV;

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

* * * * *

(h) (1) In any case in which a hospital provides inpatient services to an individual that would constitute skilled nursing facility services if provided by a skilled nursing facility or that would constitute intermediate care facility services if provided by an intermediate care facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but skilled nursing facility services or intermediate care facility services, respectively, for the individual are medically necessary and such type of facility services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for inpatient hospital services (shall continue to be made under the State plan approved under this title at the payment rate described in paragraph (2)】 *may continue to be made under the State plan but at a rate of payment not to exceed the rate described in paragraph (2) for such type of services during the period in which—*

(A) such skilled nursing facility services or intermediate care facility services (as the case may be) for the individual are medically necessary and not otherwise available to the individual (as so determined)

(B) inpatient hospital services for the individual are not medically necessary, and

(C) the individual is entitled to receive medical assistance with respect to such facility services under the State plan.

except that if the Secretary determines that [the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more], *there is not an excess of hospital beds in such hospital or in the area of such hospital which could be converted for use in providing the required skilled nursing facility services or intermediate care facility services (as the case may be)*, such payment [shall] *may be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.*

* * * * *

[(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G)]

(k)(1) *The Secretary may waive any requirements of this title with respect to provision of or payment for medical care in order to permit the State agency to share, by means of providing additional services, with any recipient of medical assistance under the State plan, any cost savings which may result from use by such recipient of medical care which is more cost-effective than medical care generally provided or paid for under such plan. A waiver shall not be provided under this paragraph unless the State provides assurances satisfactory to the Secretary that the granting of such waiver would not be inconsistent with the purposes of this title.*

(2) *The Secretary may by waiver provide that a State plan approved under this part may include as 'medical assistance' under such plan personal care services and any other services (other than room and board) approved by the Secretary which are provided pursuant to a plan of care to an individual who, but for such services, may require institutionalization in a medical institution in which the cost of his care could be reimbursed under the State plan. A waiver shall not be granted under this paragraph unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.*

(l)(1) *The Secretary may by waiver provide that a State plan approved under this part may include as "medical assistance" under such plan—*

(A) *case management;*

(B) *supervised living;*

(C) *home services;*

(D) *rehabilitation; and*

(E) *any other nonmedical services (other than room and board) approved by the Secretary,*

which are provided pursuant to a plan of care to an individual who is mentally ill, mentally retarded, or otherwise at risk of being institu-

tionalized, if such services were not provided, in a medical institution in which the cost of his care could be reimbursed under the State plan.

(2) A waiver shall not be granted under paragraph (1) unless the State provides assurances satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of any recipients of such services.

(m) Individuals specified in section 1902(a) (10) (A) shall include—

(1) any child on whose behalf foster care maintenance payments are being made under any program administered by or administered under the supervision of the State—

(A) who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative specified in section 406(a);

(B) whose removal from the home was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child; and

(C) (i) who received aid under the State plan approved under section 402 in or for the month in which court proceedings leading to the removal of the child from the home were initiated,

(ii) who would have received such aid in or for such month if application had been made therefor, or

(iii) who had been living with a relative specified in section 406(a) within six months prior to the month in which such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made; and

(2) any child on whose behalf adoption assistance payments are being made under any program administered by or administered under the supervision of the State—

(A) who but for adoption would meet the requirements specified in paragraph (1), or

(B) who but for adoption would meet the requirements of title XVI with respect to eligibility for supplemental security income benefits.

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligi-

ble for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a) (10) (A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); **[plus]**

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; **[plus]**

(3) an amount equal to—

(A) (i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A) (i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision or prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; **[plus]**

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration

of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; [plus]

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b) (3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); [plus]

[(7)] (8) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

* * * * *

(7) an amount equal to 100 percent of the reasonable costs incurred (not to exceed \$10 per vaccination) in such quarter in administering pneumococcal vaccine (including the cost of the vaccine) to any individual aged 65 or older who is eligible under the plan or who is receiving supplemental security income benefits under title XVI, by any physician or other provider who participates in the State plan, or by a State or local health department in such State; and

(d) * * *

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy [shall, at the option of the State, be retained by such State or recovered] *shall be recovered* by the Secretary pending a final determination with respect to such payment amount. [If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount

was disallowed and ending on the date of such final determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.】 *If such final determination is to the effect that such disallowance was not correct, the Secretary shall pay the proper amount of such Federal payment to the State, plus interest on such amount for the period beginning on the date such amount was recovered and ending on the date of such final determination at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.”.*

(f) * * *

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the “highest amount which would ordinarily be paid” to such family under the State’s plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan 【(without regard to section 408)】 provided for aid to such a family.

* * * * *

(i) Payment under the preceding provisions of this section shall not be made—

【(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or】

(1) with respect to any amount paid for physician services, or for medical services, supplies, and equipment (including equipment servicing) which in the judgment of the Secretary do not vary significantly in quality among suppliers, to the extent that the aggregate of such amounts for any fiscal year exceeds the aggregate which would be paid for such fiscal years for such items and services on the basis of reasonable charges determined under section 1842;

* * * * *

【(m)(1)(A) The term “health maintenance organization” means a legal entity which provides health services to individuals enrolled in such organizations and which—

【(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

【(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act

(except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4) (C), and (5) of section 1905(a), and, to the extent required by section 1902(a) (13) (A) (ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

[(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a) (1), (2), (3), (4) (C), and (5), and to the extent required by section 1902(a) (13) (A) (ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

[(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(2) (A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

[(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); and

[(ii) less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title.

[(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

[(i) (I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 319 (d) (1) (A) or 330(d) (1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

[(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4) (C), and (5) of section 1905(a) and, to the extent required by section 1902(a) (13) (A)

(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

[(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

[(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

[(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

[(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

[(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

[(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).]

* * * * *

(r) (1) (A) In order to receive payments under paragraphs (2) and [(7)](8) of subsection (a) without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is the earlier of (i) September 3, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before the date of the enactment of this subsection.

(C) if a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and [(7)](8) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2) (A) In order to receive payments under paragraphs (2) and [(7)](8) of subsection (a) without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5) (A) on or before the deadline established under subparagraph (B).

(B) the deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraph (2) and [(7)](8) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided subparagraph (A).

* * * * *

(s) (1) *Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any person during any period that an order for denial of payment (as authorized by section 1107 (c) (7)) is effective with respect to such person.*

(2) *Any order for denial of payment issued with respect to any person under section 1107 (c) (7) shall become effective, in the case of any State plan approved under this title, on the sixtieth day after the date on which the Secretary gives notice of such order to the State agency. Upon the determination of the Secretary that any such order shall cease to be effective, he shall notify each State agency to which he has submitted notice under section 1107 (c) (7) with respect to such person.*

(3) Whenever any order which has been issued by the Secretary under section 1107 (c) (7) ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such person shall be made to such State for the month in which such order ceases to be effective.

(t) (1) Notwithstanding any other provision of this section, payments under this title to any State for any fiscal year, other than—
 (A) payments under subsection (a) (3), (a) (6), or (a) (7);
 (B) interest paid under subsection (d) (5);
 (C) payments to a facility of the Indian Health Service and
 (D) payments for claims relating to expenditures made during
 fiscal year 1980 or 1981,

shall not exceed the amount of such State's cap for such fiscal year, as determined in accordance with this subsection.

(2) (A) Except as provided in paragraph (3), the amount of a State's cap for fiscal year 1982 shall be an amount equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this title (other than payments described in subparagraphs (A) through (C) of paragraph (1) and payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State.

(3) Except as provided in paragraph (3), the amount of a State's cap for fiscal year 1983 and for each fiscal year thereafter shall be an amount equal to the cap determined under this paragraph for such State for the preceding fiscal year, increased or decreased (as the case may be) by a percentage equal to the Gross National Product Implicit Price Deflator for such fiscal year (for which the cap is being determined) published by the Department of Commerce, as set forth in the President's proposed budget for such fiscal year.

(3) for fiscal year 1982 and each fiscal year thereafter—

- (A) the amount of the cap for Puerto Rico shall be \$45,000,000;
- (B) the amount of the cap for the Virgin Islands shall be \$1,000,000; and
- (C) the amount of the cap for Guam shall be \$900,000.

* * * * *

Definitions

Sec. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a) (10) (A)) not receiving aid or assistance under any

plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

[(i) under the age of 21,] (i) *under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, or any reasonable category of such individuals,*

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child [except for section 406(a)(2),] is (or would, if needy, be) a dependent child under part A of title IV,

* * * * *

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than [50] 40 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

* * * * *

TITLE XX—GRANTS TO STATES FOR SERVICES

Appropriation Authorized

[Sec. 2001. For the purpose of encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goal of—

[(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,

[(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency,

[(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families,

[(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care, or

[(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there is authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available

under this section shall be used for making payments to States under section 2002 (and to territorial jurisdictions as described in subsection (a) (2) (C) thereof).

[Payments To States

[Sec. 2002. (a) (1) From the sums appropriated therefor, the Secretary shall, subject to the provisions of this section and section 2003, pay to each State, for each quarter, an amount equal to 100 per centum of the expenditures during that quarter for child day care services (including expenditures for grants to qualified providers under section 2007) to the extent permitted by paragraph (17), 90 per centum of the total expenditures during that quarter for the provision of family planning services and 75 per centum of the total expenditures during that quarter for the provision of other services directed at the goal of—

[(A) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,

[(B) achieving or maintaining self-sufficiency, including reduction or prevention of dependency,

[(C) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families,

[(D) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care, or

[(E) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

including expenditures for administration (including planning and evaluation) and personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions). Services that are directed at these goals include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts.

[(2) (A) (i) Except as provided in clause (iii), no payment may be made under this section to any State for any fiscal year in excess of an amount which bears the same ratio to the amount specified in clause (ii) as the population of that State bears to the population of the fifty States and the District of Columbia. The Secretary shall promulgate the limitation applicable to each State for each fiscal year under this paragraph prior to the first day of the third month of the preceding fiscal year, as determined on the basis of the most recent satisfactory data available from the Department of Commerce.

[(ii) The amounts specified for purposes of clause (i) for fiscal year 1980 and each succeeding fiscal year shall be an amount (not exceeding \$3,300,000,000) equal to the indexed ceiling amount for that fiscal year as determined under subparagraph (B).

[(iii) Payment with respect to expenditures for personnel training or retraining directly related to the provision of services under this title shall be made to a State in excess of the limitation for such State promulgated under clause (i) for any fiscal year and without regard to such limitation; except that—

[(I) notwithstanding any other provision of law, payment to a State with respect to such expenditures for fiscal years 1980 and 1981 may not exceed an amount equal to 4 per centum of such State's limitation (for the fiscal year involved) under clause (i), or, if greater, an amount equal to the amount of the payment made under this title to such State with respect to such expenditures for fiscal year 1979, or equal to (a) the amount which would be payable without regard to this subclause with respect to expenditures pursuant to an appropriation made prior to October 1, 1979, by such State for fiscal year 1980, or, if less, (b) the amount determined under division (a) of this subclause reduced to the extent necessary and on a proportional basis so as to assure that the aggregate of the additional amounts payable to all States as a result of such division (a) does not exceed \$6,000,000; and

[(II) payment to a State with respect to such expenditures for fiscal year 1982 or any succeeding fiscal year may be made only if the State has submitted to the Secretary in accordance with paragraph (18) (prior to the beginning of the fiscal year involved) a training plan specifying how its funds expended for such training or retraining in that fiscal year will be used, and only with respect to expenditures included in such plan which are approved by the Secretary in accordance with criteria prescribed by him.

[(B) (i) (I) Except as otherwise provided in clauses (ii), (iii), and (iv), the indexed ceiling amount for any fiscal year shall be an amount equal to the indexed ceiling amount for the preceding fiscal year increased or decreased (as the case may be) by an amount determined under division (II).

[(II) For purposes of division (I) the amount of the increase or decrease (as the case may be) shall be an amount equal to \$2,500,000,000, multiplied by a percentage equal to the positive or negative percentage change in the Consumer Price Index prepared by the Department of Labor, and used in determining cost-of-living adjustments under section 215(i) of this Act, for the second quarter of the preceding fiscal year as compared to such index for the second quarter of the second preceding fiscal year (rounded to the nearest one-tenth of 1 per centum). For purposes of this clause the Consumer Price Index for any quarter shall be the arithmetical mean of such index for the three months in such quarter.

[(ii) If the percentage increase in the Consumer Price Index as determined under clause (i) (II) for any fiscal year exceeds the inflation rate for that fiscal year as shown for that year (or, if no rate is shown for that year, for the most recent preceding year for which

a rate is shown) in the table which appears on page 25 of Senate Budget Committee Report Numbered 96-311, then for such fiscal year such inflation rate shall be used in making the determination under clause (i) (II) instead of the percentage increase in the Consumer Price Index.

[(iii) The indexed ceiling amount determined under clause (i) shall, if not a multiple of \$100,000,000, be rounded to the next lesser amount that is a multiple of \$100,000,000.

[(iv) The indexed ceiling amount for fiscal year 1979 shall be \$2,500,000,000.

[(C) From the amounts made available under section 2001 for any fiscal year beginning with fiscal year 1980 (in addition to any sums appropriated for purposes of payments under the preceding provisions of this subsection), the Secretary shall allocate—

[(i) to the jurisdictions of Puerto Rico, Guam, and the Virgin Islands, for purposes of payments under sections 3(a) (4) and (5), 403(a) (3), 1003(a) (3) and (4), 1403(a) (3) and (4), and 1603(a) (4) and (5), with respect to services, the sums of \$15,000,000, \$500,000 and \$500,000, respectively, and

[(ii) to the jurisdiction of the Northern Mariana Island, for purposes of payments under section 403(a) (3), with respect to services and for services programs for other individuals as defined by the Secretary, the sum of \$100,000, in addition to any amounts otherwise available to such jurisdictions under this Act.

[(3) No payment may be made under this section to any State with respect to any expenditure for the provision of any service to any individual unless—

[(A) the State's services program planning meets the requirements of section 2004, and

[(B) the final comprehensive services plan in effect when the service is provided to the individual includes the provision of that service to a category of individuals which includes that individual in the descriptions required by section 2004(2) (B) and (C) of the services to be provided under the plan and the categories of individuals to whom the services are to be provided.

The Secretary may not deny payment under this section to any State with respect to any expenditure on the ground that it is not an expenditure for the provision of a service or is not an expenditure for the provision of a service directed at a goal described in paragraph (1) of this subsection.

[(4) So much of the aggregate expenditures with respect to which payment is made under this section to any State for any fiscal year as equals 50 per centum of the payment made under this section to the State for that fiscal year must be expended for the provision of services to individuals—

[(A) who are receiving aid under the plan of the State approved under part A of title IV or who are eligible to receive such aid, or

[(B) whose needs are taken into account in determining the needs of an individual who is receiving aid under the plan of the State approved under part A of title IV, or who are eligible to

have their needs taken into account in determining the needs of an individual who is receiving or is eligible to receive such aid, or

[(C) with respect to whom supplemental security income benefits under title XVI or State supplementary payments, as defined in section 2008(1), are being paid, or who are eligible to have such benefits or payments paid with respect to them, or

[(D) whose income and resources are taken into account in determining the amount of supplemental security income benefits or State supplementary payments, as defined in section 2008(1), being paid with respect to an individual, or whose income and resources would be taken into account in determining the amount of such benefits or payments to be paid with respect to an individual who is eligible to have such benefits or payments paid with respect to him, or

[(E) who are eligible for medical assistance under the plan of the State approved under title XIX.

In any case in which services are provided to individuals to whom the provisions of paragraph (14) are applied, the proportion of the expenditures for such services which are attributable to individuals described in the preceding sentence may be determined on the basis of generally accepted statistical sampling procedures.

[(5) No payment may be made under this section to any State with respect to any expenditure for the provision of any service to any individual—

[(A) who is receiving, or whose needs are taken into account in determining the needs of an individual who is receiving, aid under the plan of the State approved under part A of title IV, or with respect to whom supplemental security income benefits under title XVI or State supplementary payments, as defined in section 2008(1), are being paid, or

[(B) who is a member of a family the monthly gross income of which is less than the lower of—

[(i) 80 per centum of the median income of a family of four in the State, or

[(ii) the median income of a family of four in the fifty States and the District of Columbia.

adjusted, in accordance with regulations prescribed by the Secretary, to take into account the size of the family.

if any fee or other charge (other than a voluntary contribution) imposed on the individual for the provision of that service is not consistent with such requirements (including requirements prohibiting the imposition of any such fee or charge) as the Secretary shall prescribe.

[(6) No payment may be made under this section to any State with respect to any expenditure for the provision of any service, other than an information or referral service, family planning services, or a service directed at the goal of preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, to any individual who is not an individual described in paragraph (5), and—

[(A) who is a member of a family the monthly gross income of which exceeds 115 per centum of the median income of a family

of four in the State, adjusted, in accordance with regulations prescribed by the Secretary, to take into account the size of the family, or

[(B) who is a member of a family the monthly gross income of which—

[(i) exceeds the lower of—

[(I) 80 per centum of the median income of a family of four in the State, or

[(II) the median income of a family of four in the fifty States and the District of Columbia, adjusted, in accordance with regulations prescribed by the Secretary, to take into account the size of the family, and

[(ii) does not exceed 115 per centum of the median income of a family of four in the State, adjusted, in accordance with regulations prescribed by the Secretary, to take into account the size of the family,

unless a fee or other charge reasonably related to income is imposed on the individual for the provision of the service.

The Secretary shall promulgate the median income of a family of four in each State and the fifty States and the District of Columbia applicable to payments with respect to expenditures in each fiscal year prior to the first day of the third month of the preceding fiscal year.

[(7) No payment may be made under this section to any State with respect to any expenditure—

[(A) for the provision of medical or any other remedial care, (except as provided in paragraph (11) (D)), other than family planning services, unless it is an integral but subordinate part of a service described in paragraph (1) of this subsection and Federal financial participation with respect to the expenditure is not available under the plan of the State approved under title XIX; or

[(B) for the purchase, construction, or major modification of any land, building or other facility, or fixed equipment; or

[(C) which is in the form of goods or services provided in kind by a private entity; or

[(D) which is made from donated private funds, unless such funds—

[(i) are transferred to the State and are under its administrative control, and

[(ii) are donated to the State, without restrictions as to use, other than restrictions as to the services with respect to which the funds are to be used imposed by a donor who is not a sponsor or operator of a program to provide those services, or the geographic area in which the services with respect to which the contribution is used are to be provided, except that during fiscal years 1980 and 1981 the provisions of this clause shall not apply with respect to funds that are donated for the purpose of training or retraining as provided in subsection (a) (1), if such training or retraining is carried out by a public or nonprofit entity, and

[(iii) do not revert to the donor's facility or use if the donor is other than a nonprofit organization; or

[(E) for the provision of room or board (except as provided by paragraph (11)(C) and paragraph (11)(D)) other than room or board provided for a period of not more than six consecutive months as an integral but subordinate part of a service described in paragraph (1) of this subsection.

[With regard to ending the dependency of individuals who are alcoholics or drug addicts, the entire rehabilitative process for such individuals, including but not limited to initial detoxification, short term residential treatment, and subsequent outpatient counseling and rehabilitative services, whether or not such a process involves more than one provider of services, shall be the basis for determining whether standards imposed by or under subparagraph (A) or (E) of this paragraph have been met.

[(8) No payment may be made under this section with respect to any expenditure if payment is made with respect to that expenditure under section 403 or 423 of this Act.

[(9) (A) No payment may be made under this section with respect to any expenditure in connection with the provision of any child day care service, unless—

[(i) in the case of care provided in the child's home, the care meets standards established by the State which are reasonably in accord with recommended standards of national standard-setting organizations concerned with the home care of children, or

[(ii) in the case of care provided outside the child's home, the care meets the Federal interagency day care requirements as approved by the Department of Health, Education, and Welfare and the Office of Economic Opportunity on September 23, 1968; except that (I) subdivision III of such requirements with respect to educational services shall be recommended to the States and not required, and staffing standards for school-age children in day care centers may be revised by the Secretary, (II) the staffing standards imposed with respect to such care in the case of children under age 3 shall conform to regulations prescribed by the Secretary, and (III) the staffing standards imposed with respect to such care in the case of children aged 10 to 14 shall require at least one adult for each 20 children, and in the case of school-aged children under age 10 shall require at least one adult for each 15 children, except as provided in subparagraph (B).

[(B) The Secretary shall submit to the President of the Senate and the Speaker of the House of Representatives, after December 31, 1976, and prior to April 1, 1978, an evaluation of the appropriateness of the requirements imposed by subparagraph (A), together with any recommendations he may have for modification of those requirements. No earlier than ninety days after the submission of that report, the Secretary may, by regulation, make such modifications in the requirements imposed by subparagraph (A) as he determines are appropriate.

[(C) The requirements imposed by this paragraph are in lieu of any requirements that would otherwise be applicable under section 522(d) of the Economic Opportunity Act of 1964 to child day care services with respect to which payment is made under this section.

[(D) The requirements imposed by this paragraph or by any regulations promulgated by the Department of Health and Human Services to carry out this paragraph shall be inapplicable to child day care services provided after June 30, 1980, and prior to July 1, 1981 which meet applicable standards of State and local law.

[(10) No payment may be made under this section with respect to any expenditure for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income.

[(11) No payment may be made under this section with respect to any expenditure for the provision of any service to any individual living in any hospital, skilled nursing facility, or intermediate care facility (including any such hospital or facility for mental diseases or for the mentally retarded), any prison, or any foster family home except—

[(A) any expenditure for the provision of a service that (i) is provided by other than the hospital, facility, prison, or foster family home in which the individual is living and (ii) is provided under the State's program for the provision of the services described in paragraph (1), to individuals who are not living in a hospital, skilled nursing facility, intermediate care facility, prison, or foster family home,

[(B) any expenditure which is for the cost, in addition to the cost of basic foster care, of the provision, by a foster family home, to an individual living in that home, of a service which meets a special need of that individual, as determined under regulations prescribed by the Secretary,

[(C) any expenditure for the provision of emergency shelter provided to a child, for not in excess of thirty days, as a protective service;

[(D) any expenditure for the initial detoxification of an alcoholic or drug dependent individual, for a period not to exceed 7 days, if such detoxification is integral to the further provision of services for which such individual would otherwise be eligible under this title; and

[(E) any expenditure for the provision of emergency shelter, for not in excess of thirty days in any six-month period, provided as a protective service to an adult in danger of physical or mental injury, neglect, maltreatment, or exploitation.

[(12) No payment may be made under this section with respect to any expenditure for the provision of cash payments as a service.

[(13) No payment may be made under this section with respect to any expenditure for the provision of any service to any individual to the extent that the provider of the service or the individual receiving the service is eligible to receive payment under title XVIII with respect to the provision of the service.

[(14) (A) For purposes of paragraph (5) and (6), an individual shall, at the option of the State, be deemed to be an individual described in paragraph (5)(B) if, because of the geographic area in which any particular service is provided to him, the characteristics of the community to which it is provided, the nature of the service, the conditions (other than income) of eligibility to receive it, or other

factors surrounding its provision, the State may reasonably conclude without individual determinations of eligibility, that substantially all of the persons who receive the service are members of families with a monthly gross income which is not more than 90 per centum of the median income of a family of four in the State, adjusted (in accordance with the regulations prescribed by the Secretary) to take into account the size of the family.

[(B) The provisions of subparagraph (A) shall not be applicable to child day care services furnished to any child other than a child of a migratory agricultural workers.

[(15) No payment may be made under this section with respect to any expenditure for the provision of any health related service if such service is provided by an entity which has failed to comply with a request made by the Secretary or State agency under section 2003(d) (1) (J), for so long as such entity remains on noncompliance with such request.

[(16) Any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under the program established by this title, or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a), and the State may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1126(a) at the time the contract or arrangement was entered into or the approval was given.

[(17) (A) The total payment to a State under this section with respect to expenditures during any fiscal year for the provision of child day care services under this title (including expenditures for grants to qualified providers under section 2007) shall be equal to 100 per centum of such expenditures to the extent that such expenditures (during that fiscal year) do not exceed—

[(i) an amount which bears the same ratio to \$200,000,000 as the amount of the State's limitation under paragraph (2) (A) bears to the indexed ceiling amount for such fiscal year, in the case of fiscal year 1980 and fiscal year 1981; or

[(ii) 8 per centum of the State's limitation under paragraph (2) (A) for such fiscal year, in the case of fiscal year 1982 and any subsequent fiscal year.

[(B) Federal funds payable to a State under this title (with respect to expenditures for child day care services) at the rate specified in subparagraph (A) shall, to the maximum extent that the State determines to be feasible, be employed in such a way as to increase the employment of welfare recipients and other low-income persons in jobs related to the provision of child day care services.

[(c) Section 2002(a) of such Act is amended by adding after paragraph (17) (as added by section 202(a) of this Act) the following new paragraph:

[(18) Effective October 1, 1981, no payment may be made under this section for training or retraining expenditures except in accor-

dance with a training plan approved by the Secretary which, at a minimum—

[(A) describes how training needs were assessed and how the assessment was used to structure the training programs, the individuals to be trained, and the training resources to be used;

[(B) demonstrates that the training activities have a direct relationship to the title XX services program and to the State's staffing needs to carry out the title XX services program; and

[(C) describes the State agency's plan to monitor training programs and to evaluate the agency's overall staff training and development program.

[(b) (1) Prior to the beginning of each quarter the Secretary shall estimate the amount to which a State will be entitled under this section for that quarter on the basis of a report filed by the State containing its estimate of the amount to be expended during that quarter with respect to which payment must be made under this section, together with an explanation of the bases for that estimate.

[(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to the State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

[(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[Program Reporting

[Sec. 2003. (a) Each State which participates in the program established by this title shall make such reports concerning its use of Federal social services funds as the Secretary may by regulation provide.

[(b) Each State which participates in the program established by this title shall assure that the aggregate expenditures from appropriated funds from the State and political subdivisions thereof for the provision of service during each fiscal year (as selected by the State under section 2004(1)) within each services program period (as established under the requirements of section 2002(a) (3)) with respect to which payment is made under section 2002 is not less than the aggregate expenditures from such appropriated funds for the provision of those services during the fiscal year ending June 30, 1973, or the fiscal year ending June 30, 1974, with respect to which payment was made under the plan of the State approved under title I, VI, X, XIV, or XVI, or part A of title IV, whichever is less, except that the requirements of this subsection shall not apply to any State for any services program period if the payment to the State under section 2002, for each fiscal year any part of which is included in that services program year, with respect to expenditures other than expenditures for personnel training or retraining directly related to the provision of services, equals the allotment of the State for that fiscal year under section 2002(a) (2).

[(c) (1) If the Secretary, after reasonable notice and an opportunity for a hearing to the State, finds that there is a substantial failure to

comply with any of the requirements imposed by subsections (a) and (b) of this section, he shall, except as provided in paragraph (2), notify the State that further payments will not be made to the State under section 2002 until he is satisfied that there will no longer be any such failure to comply, and until he is so satisfied he shall make no further payments to the State.

[(2) The Secretary may suspend implementation of any termination of payments under paragraph (1) for such period as he determines appropriate and instead reduce the amount otherwise payable to the State under section 2002 for expenditures during that period by 3 per centum for each of subsections (a) and (b) of this section with respect to which there was a finding of substantial noncompliance and with respect to which he is not yet satisfied that there will no longer be any such failure to comply.

[(d) (1) Each State which participates in the program established by this title shall have a plan applicable to its program for the provision of the services described in section 2002(a) (1) which—

[(A) provides that an opportunity for a fair hearing before the appropriate State agency will be granted to any individual whose claim for any service described in section 2002(a) (1) is denied or is not acted upon with reasonable promptness;

[(B) provides safeguards which restrict the use or disclosure of information obtained in connection with administration of the State's program for the provision of the services described in section 2002(a) (1) concerning applicants for and recipients of those training standards for such services which are reasonable in accord with recommended standards of national organizations concerned with standards for such services, including standards related to admission policies for facilities providing such services, safety, sanitation, and protection of civil rights;

[(H) provides that the State's program for the provision of the services described in section 2002(a) (1) will be in effect in all political subdivisions of the State;

[(I) provides for financial participation by the State in the provision of the services described in section 2002(a) (1);

[(J) provides that any entity (other than an individual practitioner or a group of practitioners) receiving payments for the provision of health related services complies with the requirements of section 1124, and supplies (within such period as may be specified in regulations by the Secretary or by the State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (i) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (ii) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor; and

[(K) provides that the State will bar any specified individual from participation in the program for the period specified by the Secretary when required by him to do so pursuant to section 1128, and provides that no payment may be made under the program with respect to any item or service furnished by such individual during such period.

Notwithstanding clause (C), if on December 1, 1974, the State agency which administered or supervised the administration of the portion of the plan of the State for services to the aged, blind, or disabled approved under title VI of this Act which related to blind individuals was different from the agency which administered or supervised the administration of the rest of that plan, the State agency which administered or supervised the administration of the portion of the plan of the State for services to the aged, blind, or disabled related to blind individuals may be designated to administer or supervise the administration of the portion of the State's program for the provision of the services described in section 2002(a)(1) related to blind individuals and a separate State agency may be designated to administer or supervise the administration of the rest of the program; and in such case the part of the program which each agency administers, or the administration of which each agency supervises, shall be regarded as a separate program for the provision of the services described in section 2002(a)(1) for purposes of this title. The date selected by the State pursuant to section 2004(1) as the beginning of the services program period for each of the separate programs shall be the same.

[(2) The Secretary shall approve any plan which complies with the provisions of paragraph (1).

[(e)(1) No payment may be made under section 2002 to any State which does not have a plan approved under subsection (d).

[(2) In the case of any States plan which has been approved by the Secretary under subsection (d), if the Secretary, after reasonable notice and an opportunity for a hearing to the State, finds—

[(A) that the plan no longer complies with the provisions of subsection (d)(1), or

[(B) that in the administration of the plan there is a substantial failure to comply with any such provision.

the Secretary shall, except as provided in paragraph (3), notify the State that further payments will not be made to the State under section 2002 until he is satisfied that there will no longer be any such failure to comply, and until he is so satisfied he shall make no further payments to the State.

[(3) The Secretary may suspend implementation of any termination of payments under paragraph (2) for such period as he determines appropriate and instead reduce the amount otherwise payable to the State under section 2002 for expenditures during that period by 3 percent for each clause of subsection (d)(1) with respect to which there is a finding of noncompliance and with respect to which he is not yet satisfied that there will no longer be any such failure to comply.

[(f) The provisions of section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 shall be applicable to services provided by any State pursuant to this title with respect to individuals suffering from drug addiction or alcoholism.

[Services Program Planning

[Sec. 2004. A State's services program planning meets the requirements of this section if, for the purpose of assuring public participation in the development of the program for the provision of the services described in section 2002(a) (1) within the State—

[(1) for each services program period, the beginning of the fiscal year of the Federal Government, the State government, or the political subdivisions of such State is established as the beginning of the State's services program period, and the end of such fiscal year, the succeeding fiscal year, or the second succeeding fiscal year is established as the end of the State's services program period; and

[(2) at least ninety days prior to the beginning of the State's services program period, the chief executive officer of the State, or such other official as the laws of the State provide, publishes and makes generally available (as defined in regulations prescribed by the Secretary after consideration of State laws governing notice of actions by public officials) to the public a proposed comprehensive services program plan prepared by the agency designated pursuant to the requirements of section 2003(d) (1) (C) and, unless the laws of the State provide otherwise, approved by the chief executive officer, which sets forth the State's plan for the provision of the services described in section 2002(a) (1) during that period, including—

[(A) the objectives to be achieved under the program,

[(B) the services to be provided under the program, including at least one service directed at at least one of the goals in each of the five categories of goals set forth in section 2002(a) (1) (as determined by the State) and including at least three types of services (selected by the State) for individuals who are recipients of supplemental security income benefits under title XVI and who are in need of such services, together with a definition of those services and a description of their relationship to the objectives to be achieved under the program and the goals described in section 2002(a) (1),

[(C) the categories of individuals to whom those services are to be provided, including any categories based on the income of individuals or their families,

[(D) the geographic areas in which those services are to be provided, and the nature and amount of the services to be provided in each area,

[(E) a description of the planning, evaluation, and reporting activities to be carried out under the program,

[(F) the sources of the resources to be used to carry out the program,

[(G) a description of the organizational structure through which the program will be administered, including the extent to which public and private agencies and volunteers will be utilized in the provision of services,

[(H) a description of how the provision of services under the program will be coordinated with the plan of the State approved under part A of title IV, the plan of the State

developed under part B of that title, the supplemental security income program established by title XVI, the plan of the State approved under title XIX, and other programs for the provision of related human services within the State, including the steps taken to assure maximum feasible utilization of services under these programs to meet the needs of the low income population,

[(I) the estimated expenditures under the program, including estimated expenditures with respect to each of the services to be provided, each of the categories of individuals to whom those services are to be provided, and each of the geographic areas in which those services are to be provided, and a comparison between estimated non-Federal expenditures under the program and non-Federal expenditures for the provision of the services described in section 2002(a)(1) in the State during the preceding services program period, and

[(J) a description of the steps taken, or to be taken, to assure that the needs of all residents of, and all geographic areas in, the State were taken into account in the development of the plan; and

[(3) public comment on the proposed plan is accepted for a period of at least forty-five days; and

[(4) at least forty-five days after publication of the proposed plan and prior to the beginning of the State's services program period, the chief executive officer of the State, or such other official as the laws of the State provide, publishes a final comprehensive annual services program plan prepared by the agency designated pursuant to the requirements of section 2003(d)(1)(C) and, unless the laws of the State provide otherwise, approved by the chief executive officer, which sets forth the same information required to be included in the proposed plan, together with an explanation of the differences between the proposed and final plan and the reasons therefor; and

[(5) any amendment to a final comprehensive services program plan is prepared by the agency designated pursuant to section 2003(d)(1)(C), approved by the chief executive officer of the State unless the laws of the State provide otherwise, and published by the chief executive officer of the State, or such other official as the laws of the State provide, as a proposed amendment on which public comment is accepted for a period of at least thirty days, and then prepared by the agency designated pursuant to section 2003(d)(1)(C), approved by the chief executive officer of the State unless the laws of the State provide otherwise, and published by the chief executive officer of the State, or such other official as the laws of the State provide, as a final amendment, together with an explanation of the differences between the proposed and final amendment and the reasons therefor; and

[(6) in the case of a State that adopts a services program planning period of longer than one year, the State agency publishes and makes generally available such information concerning the comprehensive services program at such times as the Secretary may by regulation require;

[Effective Date of Regulations Published by the Secretary

[Sec. 2005. No final regulation published by the Secretary under this title shall be effective with respect to payments under section 2002 for expenditures during any quarter commencing before the beginning of the first services program period established by the State under the requirements of section 2002(a)(3) which begins at least sixty days after the publication of the final regulation.

[Evaluation; Program Assistance

[Sec. 2006. (a) The Secretary shall provide for the continuing evaluation of State programs for the provision of the services described in section 2002(a)(1).

[(b) The Secretary shall make available to the States assistance with respect to the content of their services program, and their services program planning, reporting, administration, and evaluation.

[(c) Within six months after the close of each fiscal year, the Secretary shall submit to the Congress a report on the operation of the program established by this title during that year, including—

[(1) the evaluations carried out under subsection (a) and the results obtained therefrom, and

[(2) the assistance provided under subsection (b) during that year.

[Child Day Care Services

[Sec. 2007. (a) Subject to subsection (b), sums granted by a State to a qualified provider of child day care services (as defined in subsection (c)) to assist such provider in meeting its work incentive program expenses (as defined in subsection (c)) with respect to individuals employed in jobs related to the provision of child day care services in one or more child day care facilities of such provider, shall be deemed for purposes of section 2002 to constitute expenditures made by the State in accordance with the provisions of this title for the provision of child day care services.

[(b) The provisions of subsection (a) shall not be applicable with respect to any grant made to a particular qualified provider of child day care services to the extent that (as determined by the Secretary) such grant is or will be used to pay wages to any employee at an annual rate in excess of \$6,000, in the case of a public or nonprofit private provider, or at an annual rate in excess of \$5,000, or to pay more than 80 per centum of the wages of any employee, in the case of any other provider.

[(c) For purposes of this subsection—

[(1) the term “qualified provider of child day care services”, when used in reference to a recipient of a grant by a State, includes a provider of such services only if, of the total number of children receiving such services from such provider in the facility with respect to which the grant is made, at least 20 per centum thereof have some or all of the costs for the child day care services so furnished to them by such provider paid for under the State’s services program conducted pursuant to this title; and

[(2) the term “work incentive program expenses” means expenses of a qualified provider of child day care services which

constitute work incentive program expenses as defined in section 50B(a)(1) of the Internal Revenue Code of 1954, or which would constitute work incentive program expenses as so defined if the provider were a taxpayer entitled to a credit (with respect to the wages involved) under section 40 of such Code.

[Definitions

[Sec. 2008. For purposes of this title—

【(1) the term “State supplementary payment” means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits, as determined by the Secretary, and

【(2) the term “State” means the fifty States and the District of Columbia.】

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

Purposes of Title; Authorization of Appropriations

Sec. 2001. *For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—*

(1) *achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;*

(2) *achieving or maintaining self-sufficiency, including reduction or prevention of dependency;*

(3) *preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;*

(4) *preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care;*

(5) *securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions;*

(6) *assuring that children removed from their families are protected, are receiving appropriate care, and are reunited with their families when appropriate; and*

(7) *facilitating adoption for hard to place children who cannot return to their families, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this title.*

Payments to States

Sec. 2002. (a) (1) *Each State shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the*

goals set forth in section 2001, subject to the provisions of section 2006 and the requirements of this title.

(2) *For purposes of paragraph (1)—*

(A) *services which are directed at the goals set forth in section 2001 include, but are not limited to, child welfare services, foster care payments, adoption assistance, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and*

(B) *expenditures for such services may include expenditures for administration (including planning and evaluation) and personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions).*

(b) *The Secretary shall make payments in accordance with section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213) to each State from its allotment for use under this title.*

(c) *Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.*

(d) *A State may transfer up to 10 percent of its allotment under section 2003 for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or energy or emergency assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this title shall be treated as if they were paid to the State under this title but shall not affect the computation of the State's allotment under this title. The State shall inform the Secretary of any such transfer of funds.*

(e) *A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this title.*

Allotments

Sec. 2003. *The allotment for each State for any fiscal year shall be an amount which bears the same ratio to \$2,639,000,000 as the total amount allotted to such State (without regard to any reallocation), or in the absence of an allotment, the total amount obligated to such State, or in the absence of such an allotment or obligation, the total amount paid to such State (as determined by the Secretary on the basis of claims for payment submitted by the State, and approved by*

the Secretary, on or before April 1, 1982) for fiscal year 1981 under parts B and E of title IV (other than grants for research under section 426 (a) (1) (A) and (B) and for contracts and cooperative arrangements under section 426 (a) (2)), under part A of title IV for foster care payments (and associated administrative expenses) authorized under section 408, under this title (as in effect on September 30, 1981), and for social services in accordance with section 1108 (a) of this Act, bears to the total amount so allotted, obligated, or paid to all States under those authorities for fiscal year 1981.

State Administration

Sec. 2004. *Prior to expenditure by a State of payments made to it under section 2002 for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this title, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall contain a statement of the State's plans and timetable for implementation of a program meeting the requirements of section 2006, and shall also contain such information as the Secretary may require on the implementation or operation of such a program, including a statement of intended expenditures, individuals to be served, and services to be provided under such a program. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this title, and any revision shall be subject to the requirements of the previous sentence.*

Limitations on Use of Grants

Sec. 2005. *(a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—*

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than foster care maintenance payments, adoption assistance payments, costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for foster care maintenance payments for foster care provided by a public foster care institution which accommodates more than 25 children;

(5) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

(6) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(7) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(8) for any child day care services unless such services meet applicable standards of State and local law; or

(9) for the provision of cash payments as a service (except as otherwise provided in this section).

(b) The Secretary may waive the limitation contained in subsection (a) (1) and (5) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

Requirements Relating to Adoption Assistance, Foster Care, and Child Welfare Services

Sec. 2006. (a) (1) The amount of the payment to any State under section 2002 shall be reduced in an amount determined under paragraph (2) for any fiscal year in which such State does not meet the requirements of subsections (b) and (c) of this section (relating to child welfare services, foster care, and adoption assistance).

(2) The amount of the reduction under paragraph (1) for any fiscal year shall be an amount which bears the same ratio to such State's allotment for such fiscal year as the total amount paid to such State for fiscal year 1981 (determined in the same manner as under section 2003) under parts IV-B and IV-E (other than grants for research under section 426(1) (A) and (B) and for contracts and cooperative arrangements under section 426(a)(2)) and under part IV-A for foster care payments (including associated administrative expenses) authorized under section 408, bears to the total amount paid to such State for fiscal year 1981 under such provisions and under this title and for social services in accordance with section 1108(a).

(b) In order to meet the requirements of this subsection for any fiscal year, the chief executive officer of the State must certify to the Secretary that such State has in effect a child welfare, foster care, and adoption assistance program, which provides, in accordance with the requirements of parts IV-B and IV-E and section 408 (as those provisions would have been in effect for such fiscal year had they not been repealed, and including any such requirements which were contingent upon a specific amount being appropriated under part IB-B) except where otherwise provided under this title, and which includes, to the extent required by such provisions—

(1) a services program designed to help children, whose custody the State would otherwise be required to assume, remain, if appropriate, in their homes;

(2) a system in which, for each child for whose custody the State is responsible, a plan is prepared (and subjected to periodic court or administrative review) that is designed—

(A) to achieve placement in the least restrictive (most-family-like) setting available, or a return to the child's own home, or an adoption placement, as appropriate;

(B) to ensure that the child receives proper care;

(C) in the case of a foster care placement, to ensure periodic hearings by a court (or agency approved by the court) to review or determine the placement then in the best interests of the child; and

(D) in the case of a foster care placement, to provide services to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care;

(3) adoption assistance for children with special needs;

(4) methods for establishing, and periodically reviewing, standards for foster family homes and child care institutions, designed to ensure appropriate care; and

(5) a statewide information system, to be implemented by October 1, 1983, from which the status, demographic characteristics, location, and goals for the placement of every child who is in foster care, or who has been in such care within the preceding twelve months, can readily be determined.

(C) In order to meet the requirements of this subsection for any fiscal year—

(1) a State must spend, for such fiscal year, for adoption assistance, foster care, and child welfare services, an amount equal to or greater than 75 percent of the amount expended by such State for fiscal year 1981 under parts IV-B and IV-E (other than grants for research under section 426(a)(1)(A) and (B)), and under part IV-A for foster care payments (including associated administrative expenses) authorized under section 408; and

(2) the proportion of the amount paid to such State under this title for such fiscal year which is expended for foster care payments (including associated administrative expenses) may not exceed the proportion of the payments to such State for fiscal year 1981 under parts IV-B and IV-E (other than grants for research under section 426(a)(1)(A) and (B)), under part IV-A for foster care payments (including associated administrative expenses) authorized under section 408, under this title, and for social services under section 1108, which was expended for foster care payments (including associated administrative expenses).

Child Day Care Services

Sec. 2007. (a) Subject to subsection (b), sums granted by a State to a qualified provider of child day care services (as defined in subsection (c)) to assist such provider in meeting its work incentive pro-

gram expenses (as defined in subsection (c)) with respect to individuals employed in jobs related to the provision of child day care services in one or more child day care facilities of such provider, shall be deemed for purposes of section 2002 to constitute expenditures made by the State in accordance with the provisions of this title for the provision of child day care services.

(b) The provisions of subsection (a) shall not be applicable with respect to any grant made to a particular qualified provider of child day care services to the extent that (as determined by the Secretary) such grant is or will be used to pay wages to any employee at an annual rate in excess of \$6,000, in the case of a public or nonprofit private provider, or at an annual rate in excess of \$5,000, or to pay more than 80 percent of the wages of any employee, in the case of any other provider.

(c) For purposes of this subsection—

(1) the term “qualified provider of child day care services”, when used in reference to a recipient of a grant by a State, includes a provider of such services only if, of the total number of children receiving such services from such provider in the facility with respect to which the grant is made, at least 20 percent thereof have some or all of the costs for the child day care services so furnished to them by such provider paid for under a program conducted pursuant to this title; and

(2) the term “work incentive program expenses” means expenses of a qualified provider of child day care services which constitute work incentive program expenses as defined in section 50B (a)(1) of the Internal Revenue Code of 1954, or which would constitute work incentive program expenses as so defined if the provider were a taxpayer entitled to a credit (with respect to the wages involved) under section 40 of such Code.

Reports and Audits

Sec. 2008. (a) Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this title. Reports shall be in such form, contain such information, and be of such frequency (but not less often than every two years) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 2004. Reports shall include information on the implementation and operation of a program in accordance with the requirements of section 2006, including a report on the State's compliance with the timetable submitted pursuant to section 2004 for implementation of such a program, information on the use of payments to the State under this title for such a program, information on the individuals served and the services provided under such program, and such other information as the Secretary may require. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(b) Each State shall, not less often than every two years, audit

its expenditures from amounts received (or transferred for use) under this title. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this title, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this title, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

(c) For other provisions requiring States to account for Federal grants, see section 202 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4212).

INTERNAL REVENUE CODE OF 1954 (AS AMENDED) SUBTITLE A—INCOME TAXES

CHAPTER 1. NORMAL TAXES AND SURTAXES

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SUBCHAPTER B—COMPUTATION OF TAXABLE INCOME

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Part VI—Itemized Deductions for Individuals and Corporations

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SEC. 162. TRADE OR BUSINESS EXPENSES

* * * * *

(h) Health Plans.—

(1) General rule.—The expenses paid or incurred by an employer for a health plan shall not be allowed as a deduction under this section if the health plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner.

(2) Health plan.—For purposes of this subsection the term “health plan” means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(e)) to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

[(h)](i) Cross reference.

(1) For special rule relating to expenses in connection with subdividing real property for sale, see section 1237.

(2) For special rule relating to the treatment of payments by a transferee of a franchise, trademark, or trade name, see section 1253.

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SUBTITLE C—EMPLOYMENT TAXES

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NO. 1

OMNIBUS BUDGET RECONCILIATION ACT
OF 1981

CONFERENCE REPORT

[To accompany H.R. 3982]



JULY 29, 1981.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1981

OMNIBUS BUDGET RECONCILIATION ACT OF 1981

JULY 29, 1981.—Ordered to be printed

Mr. JONES of Oklahoma, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3982]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3982) to provide for reconciliation pursuant to section 301 of the first concurrent resolution on the budget for the fiscal year 1982, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Omnibus Budget Reconciliation Act of 1981".

TABLE OF CONTENTS

Title I. Agriculture, forestry, and related programs.
Title II. Armed services and defense-related programs.
Title III. Banking, housing, and related programs.
Title IV. District of Columbia.
Title V. Education programs.
Title VI. Human services programs.
Title VII. Employment programs.
Title VIII. School lunch and child nutrition programs.
Title IX. Health services and facilities.
Title X. Energy and energy-related programs.
Title XI. Transportation and related programs.
Title XII. Consumer product safety and communications.

Title XIII. International affairs.

Title XIV. Department of Interior and related programs.

Title XV. Department of Justice and related provisions.

Title XVI. Maritime and related programs.

Title XVII. Civil service and postal service programs; governmental affairs generally.

Title XVIII. Water resource development and economic development programs.

Title XIX. Small business.

Title XX. Veterans' programs.

Title XXI. Medicare, medicaid, and maternal and child health.

Title XXII. Federal Old-Age, Survivors, and Disability Insurance program.

Title XXIII. Public assistance programs.

Title XXIV. Unemployment compensation.

Title XXV. Trade adjustment assistance.

Title XXVI. Low-income home energy assistance.

Title XXVII. Health professions.

PURPOSE

SEC. 2. It is the purpose of this Act to implement the recommendations which were made by specified committees of the House of Representatives and the Senate pursuant to directions contained in part A of title III of the first concurrent resolution on the budget for the fiscal year 1982 (H. Con. Res. 115, 97th Congress), and pursuant to the reconciliation requirements which were imposed by such concurrent resolution as provided in section 310 of the Congressional Budget Act of 1974.

TITLE I—AGRICULTURE, FORESTRY, AND RELATED PROGRAMS

Subtitle A—Food Stamp Program Reductions and Other Reductions in Authorization for Appropriations

PART 1—FOOD STAMP PROGRAM REDUCTIONS

FAMILY UNIT REQUIREMENT

SEC. 101. Section 3(i) of the Food Stamp Act of 1977 is amended by—

(1) inserting before the period at the end of the first sentence “; except that parents and children who live together shall be treated as a group of individuals who customarily purchase and prepare meals together for home consumption even if they do not do so, unless one of the parents is sixty years of age or older”; and

(2) striking out “neither” in the second sentence and inserting “no” in lieu thereof.

BOARDERS

SEC. 102. Section 3(i) of the Food Stamp Act of 1977 is amended by—

(1) striking out in clause (1) of the first sentence “or else pays compensation to the others for such meals,”;

(2) striking out in clause (2) of the first sentence “or else live with others and pay compensation to the others for such meals”; and

NO. 2

OMNIBUS BUDGET RECONCILIATION ACT
OF 1981

CONFERENCE REPORT

[To accompany H.R. 3982]



JULY 29, 1981.—Ordered to be printed

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do so, however, only after adequate notice and an opportunity for a hearing conducted within the State and after the Secretary has conducted an investigation.

AGE DISCRIMINATION AMENDMENT

Conference Agreement

Conferees agreed to H.R. 3831 with Senate amendments. The present law restricts any individual over the age of 64 from being appointed Surgeon General of the United States Public Health Service Corps. This bill removes this arbitrary age restriction and specifies that the nominee have significant experience and specialized training in public health programs.

The post of Surgeon General is filled by presidential appointment subject to confirmation by the United States Senate. It is not the intention of this amendment to limit the responsibility of the Senate to determine the qualifications of the nominee.

BLACK LUNG CLINICS

Senate Bill

The Senate bill proposed to repeal the authority for the black lung clinics contained in Section 427(a) of the Federal Mine Safety and Health Act of 1977 and to include this program in its health services block grant.

House Bill

No comparable provision.

Conference Agreement

The conference agreement does not repeal the black lung clinic authority and does not include it in a block grant.

MATERNAL AND CHILD HEALTH BLOCK GRANT

1. Authorization of Appropriations

(a) House bill.—The House bill provides for the consolidation of the following programs into a block grant to the States under Title V of the Social Security Act: Maternal and Child Health (MCH) and Crippled Children's (CC) Services; Supplemental Security Income for Disabled Children; Lead-based Paint Poisoning Prevention; Sudden Infant Death Syndrome; Hemophilia Treatment Centers; and Adolescent Pregnancy.

Senate amendment.—Similar provision, except does include Genetic Diseases programs in the MCH block grant but does not include Adolescent Pregnancy under the MCH block grant.

Conference agreement.—The conference agreement includes the Senate provision with modification to include the adolescent pregnancy program.

(b) House bill.—The House bill authorizes an appropriation of \$394,000,000 in fiscal year 1982 for the MCH block grant.

Senate amendment.—The Senate amendment authorizes an appropriation of \$334,500,000 in fiscal year 1982 for the MCH block grant.

Conference agreement.—The conference agreement provides for an authorization of \$373,000,000 for fiscal year 1982 for the MCH block grant.

(c) House bill.—The House bill authorizes increases in appropriations for the MCH block grant for fiscal year 1983 and each fiscal year thereafter by a percentage equal to one-half of the percentage increase in the Consumer Price Index.

Senate bill.—The Senate bill authorizes an appropriations of \$334,500,000 in fiscal year 1983 and each fiscal year thereafter.

Conference agreement.—The conference agreement includes the Senate provision with modification to authorize appropriations of \$373,000,000 for fiscal year 1983 and each fiscal year thereafter.

2. Allotments to States and Federal Set-Aside

(a) House bill.—The House bill requires the Secretary to use 15 percent of the amounts appropriated for the MCH block grant each fiscal year for special projects of regional or national significance, for research, for training, and for the continuation of funding of grants to (1) public or nonprofit private institutions of higher learning for training personnel, (2) multi-State regional resource centers for handicapped children, and (3) hemophilia diagnostic and treatment centers.

Senate amendment.—The Senate amendment includes a similar provision, except requires that in fiscal year 1982 the Secretary retain 10 percent of the amount appropriated, and in fiscal year 1983 and fiscal year 1984 an amount not to exceed 10 percent for special projects, training, and research.

Conference agreement.—The conference agreement follows the Senate provision with modifications to (1) provide for a 15 percent set aside in fiscal year 1982, and up to 15 percent but not less than 10 percent in fiscal years thereafter; and (2) include the funding of voluntary genetic disease testing, counseling, and information development and dissemination programs, and comprehensive hemophilia diagnostic and treatment centers within the purposes of the set-aside. The conferees intend that, in administering this section, the Secretary give special consideration to the continuation of existing genetic disease and hemophilia programs. The conferees further intend that, if they so choose, States may fund genetic disease programs from their allotments.

(b) House bill.—The House bill provides for allocation of the remainder of each fiscal year's total MCH block grant appropriation among States on the basis of each State's relative share of the fiscal year 1980 expenditures under the programs consolidated into the block grant.

Senate amendment.—The Senate amendment includes a similar provision, except that the allotment would be based on each State's relative share of fiscal year 1981 expenditures under the programs consolidated into the block grant.

Conference agreement.—The House recedes.

(c) House bill.—The House bill provides that, if the amount available for allotment to the States in any fiscal year exceeds the total amounts expended under the consolidated programs in fiscal

year 1980, the excess would be based upon each State's relative share of low-income children in all the States.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with modification providing that the allocation of excess funds shall be applied in fiscal year 1984 and fiscal years thereafter, and that this excess refers to the amount exceeding the funds available for allotment in fiscal year 1983.

(d) House bill.—The House bill provides that if any States do not qualify for allotments, do not request full allotment, or are subject to offset of amounts determined by audits to have been improperly spent, the excess amounts are to be distributed among the remaining States.

Senate amendment.—No provision.

Conference agreement.—The Senate recedes.

(e) House bill.—The House bill requires the Secretary, in consultation with the Comptroller General, to study and report to Congress by January 1, 1983, on equitable allotment formulas which take into account the State population, number of live births, number of handicapped children, number of low income mothers and children, and State financial resources.

Senate amendment.—The Senate amendment requires the Secretary to devise a formula for equitable distribution of funds among the States and to report to Congress with recommendations by September 30, 1982.

Conference agreement.—The conference agreement includes the House provision with modifications to (1) change the effective date to June 30, 1982, and (2) include consideration of "other factors" deemed appropriate by the Secretary in devising an equitable formula.

3. Payments to States

(a) House bill.—The House bill requires the Secretary to make payments as provided by section 203 of the Intergovernmental Cooperation Act to the State health agency of each State.

Senate amendment.—Similar provision, except requires that payment be made to each State.

Conference agreement.—The House recedes.

(b) House bill.—The House bill limits Federal allotments to one-half of the total amount spent each quarter by a State for purposes of the block grant.

Senate amendment.—The Senate amendment requires that the amounts of State funds spent by a State for the purposes of the block grant bear a certain ratio to its Federal allotment. This ratio is determined by dividing the amount a State was required to spend in fiscal year 1981 under Title V by the amount of Federal funds received by the State under Title V and the other consolidated programs that year. The Secretary is required to reduce the amount allotted to a State where necessary to assure that this ratio is achieved.

Conference agreement.—The conference agreement follows the House provision with a modification to require expenditure of three State dollars for each four Federal dollars received through the block.

4. Use of Allotment Funds

(a) House bill.—The House bill requires States to pass one-third of their block grant allotments through to counties and municipalities.

Senate amendment.—No provision.

Conference agreement.—The House recedes. In adopting the Senate amendment, the conferees seek to avoid creating difficulties for those States where local health departments play no role, or a more limited role, in providing maternal and child health services. However, it is the intention of the conferees that States maximize the amount of funding available for the direct delivery of services, and that local health departments (where they exist) and other local public health entities receive at least the same proportion of funding in future years as they have in the past for the provision of appropriate services.

(b) House bill.—The House bill prohibits the use of block grant funds for:

(1) inpatient services, other than inpatient services provided to handicapped children and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) purchase or improvement of land or buildings; the purchase or major medical equipment; or the funding of depreciation or interest expense relating to such purchase or improvement;

(4) satisfying any requirement for the expenditure of non-Federal funds;

(5) providing financial assistance to other than a public or nonprofit private entity.

Senate amendment.—The Senate amendment prohibits the use of block grant funds for:

(1) inpatient services to extent disapproved by the Secretary;

(2) similar provision;

(3) similar provision, except does not bar use of funds to purchase major medical equipment or to fund depreciation or interest expenses; and authorizes waivers if justified by extraordinary circumstances;

(4) similar provision;

(5) no provision.

Conference agreement.—The conference agreement includes:

(1) House provision with a modification to include inpatient services for high-risk pregnant women and infants.

(2) Senate provision.

(3) Senate provision with a modification to bar use of grant funds to purchase major medical equipment.

(4) Senate provision.

(5) House provision with a modification to specify applicability to providing funds for research and training.

(c) House bill.—No provision.

Senate amendment.—The Senate amendment authorizes the State to transfer up to 10 percent of its allotments for use under other Federal block grants for health services, prevention, social services, or home energy and emergency assistance, if those block grants also allow funds to be transferred to this maternal and child health block grant.

Conference agreement.—The Senate recedes.

(d) House bill.—The House bill requires that at least 85 percent of a State's allotment must be used for the provision of health services to mothers and children, with special consideration (where appropriate) to the funding of special projects previously funded in the State under Title V. States would be authorized to spend up to 15 percent of their allotments for program administration, training, technical assistance, and program evaluation.

Senate amendment.—The Senate amendment provides that a State may use a portion of its allotment to purchase technical assistance from public or private entities if the State determines that such assistance is appropriate in carrying out programs under this title.

Conference agreement.—The conference agreement modifies the House bill to require that a substantial portion of all funds, Federal and State, expended by a State under this block grant be used for the provision of health services to mothers and children, with special consideration to the funding of special projects previously funded in the State under title V. States would be authorized to use their Federal allotment to purchase technical assistance where necessary. In removing the 15 percent ceiling on administrative services, the conferees do not intend that States spend that amount or more on administrative and other nonservice expenditures. It is the understanding of the conferees that administrative outlays under the current title V program average about 7.5 percent of total program outlays. The conferees intend that States, and if a State chooses to pass funds through those localities, would at least hold their administrative expenses to 7.5 percent of the total outlays, and expect that they economize even further to the maximum extent possible. The conferees expect that, in evaluating the performance of the States under this block grant, the Secretary and the Comptroller General will give particular consideration to a State's (or locality's) compliance with this standard.

(e) House bill.—The House bill requires that a State use a reasonable proportion of its funds (based upon its previous funding patterns) to reduce infant mortality, reduce preventable diseases and handicapping conditions, increase maternity care, increase child immunizations, and increase assessments of, and services to, low-income children.

Senate amendment.—No provision.

Conference agreement.—Senate recedes.

(f) House bill.—The House bill requires Secretary to assure that applicants for special projects, research, or training funds set-aside in the Federal allotments, establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds.

Senate amendment.—No provision.

Conference agreement.—Senate recedes.

(g) House bill.—The House bill allows for the continuation of the practice of assigning Federal specialists to assist in the operation and management of State and local programs and counting the cost of this assignment against the grant.

Senate amendment.—No provision.

Conference agreement.—Senate recesses. The conferees intend that this arrangement is to continue on a temporary basis, with such assignments lasting, on the average, 6 months.

5. Description of Intended Expenditures and Statement of Assurances

(a) House bill.—The House bill requires that States transmit to the Secretary a description of intended use of block grant funds each fiscal year, including the services to be provided, the categories of persons to be served, and the data to be collected. Requires the Secretary to determine promptly whether the description meets these requirements.

Senate amendment.—The Senate bill requires that States make available to the Secretary a report on the intended use of block grant funds, including a consideration of the needs of the State for services, a statement of goals and objectives for meeting those needs, information on the types of services to be provided and the categories of individuals to be served, and a description of the progress made in meeting the State's service and outcome goals.

Conference agreement.—The conference agreement includes the Senate provision with modifications to (1) require transmittal of the report to the Secretary, and (2) delete the requirement that the report include a description of progress made.

(b) House bill.—The House bill requires States to transmit to the Secretary a statement of assurances that:

(1) the State health agency will be responsible for administration of the State's allotment;

(2) the State has identified populations, areas and locations with a need for maternal and child health services and will provide a fair method (as determined by the State) for allocating funds;

(3) funds will be used only to carry out the purposes of the block grant;

(4) charges for services provided under the block grant will be public, will not be imposed on low income mothers or children, and will reflect income, resources, and family size. ("Low income" means an individual or family with an income determined to be below the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 624 of the Economic Opportunity Act of 1964.); and

(5) the State will identify guidelines for delivery of appropriate care and methods for assuring quality.

Requires the Secretary to determine promptly whether the statement meets these requirements.

Senate amendment.—The Senate amendment includes no such provision except that it requires that the State health agency administer the State's allotment.

Conference agreement.—The conference agreement provides that:

(1) the House recesses.

(2) the Senate recesses.

(3) the Senate recesses.

(4) the Senate recesses.

(5) the Senate recesses, with a modification deleting the requirement that the Secretary review the State's submission.

6. Reports and Audits

(a) House bill.—The House bill requires States to submit to the Secretary annual reports of their activities under the block grant.

Senate amendment.—The Senate amendment requires States to prepare reports on their activities under the block grant at least once every 2 years, and to make such reports available for public inspection within the State.

Conference agreement.—The conference agreement includes the House provision.

House bill.—The House bill requires that the reports be in a form and contain information determined by the Secretary, in consultation with the States and the Comptroller General, to be necessary to assure:

- (1) an accurate description of activities;
- (2) a complete record of the purposes for which funds were spent, the recipients of funds, and the progress made toward achieving the goals of the block grant; and
- (3) the extent to which funds were expended consistent with the State's description of activities and statement of assurances.

Senate amendment.—The Senate amendment requires that the reports be in such form and contain such information as the State finds necessary to:

- (1) assure an accurate description of activities;
- (2) secure a complete record of the purposes for which funds were spent; and
- (3) determine the extent to which funds were expended consistent with the State's report on intended use of payment.

Conference agreement.—The conference agreement includes the House provision.

(c) House bill.—The House bill requires the Secretary to report annually to the Congress on special projects, research, and training activities funded under the Federal set-aside.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision, with a modification requiring the Secretary to provide reports to the States.

(d) House bill.—The House bill requires the States to provide for an annual audit of Federal block grant funds through an independent entity in accordance with the Comptroller General's standards and to transmit a copy of this audit to the Secretary.

Senate amendment.—The Senate amendment requires the States to provide for an audit at least every 2 years of Federal block funds through an independent entity in accordance with generally accepted auditing standards.

Conference agreement.—The conference agreement includes the House provision, with a modification requiring audits every 2 years. The conferees have adopted the Comptroller General's standards as the appropriate standards for audits under this title. These standards incorporate the standards for financial audits established by the American Institute of Certified Public Accountants and are required by statute to be used by Inspectors General in auditing federally assisted programs. In addition, the Office of Management and Budget currently requires State and local governments to adhere to the Comptroller General's standards through Attachment P to Circular A-102.

The conferees expect that the States will initiate efforts to conduct audits of program economy, efficiency, and effectiveness in accordance with the Comptroller General's standards. Further, the Committee expects that, to the extent practicable, HHS' Inspector General and the Comptroller General will provide technical assistance to the States in planning and carrying out these audits.

To help ensure that Federal program funds are used only for authorized purposes and are used economically, efficiently and effectively, the Committee believes that the Comptroller General must exercise his traditional audit responsibilities. Accordingly, the Committee bill authorizes access to program-related records of the States, their political subdivisions, or their subrecipient organizations.

7. Fraud and Abuse

(a) House bill.—The House bill provides criminal penalties (up to \$25,000 in fines or 5 years' imprisonment, or both) for fraudulent statements or concealment of material facts relating to payments for services under the MCH block grant.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

(b) House bill.—The House bill provides for imposition of civil money penalties and assessments for fraudulent or otherwise unlawful claims for payment for services under the block grant.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

8. Nondiscrimination

(a) House bill.—The House bill provides that the current prohibitions against discrimination on the basis of age, handicap, sex (in educational institutions), race, color, or national origin in Federal programs also apply to programs and activities funded under the MCH block grant.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

(b) House bill.—The House bill prohibits discrimination on the basis of sex and religion in any programs or activities funded under the MCH block grant.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision. It is the intent of the conferees that nothing in the bill could be construed to require a State under the MCH block grant to compel an individual to undergo any medical screening, examination, diagnosis, or treatment or to accept health care or services (other than services to prevent the spread of infectious or contagious diseases or for environmental health purposes) if such services would be contrary to his religious beliefs.

(c) House bill.—The House bill requires that the Secretary provide the Governor of a State notice and an opportunity to correct any noncompliance within the State before referring the matter to the Attorney General or taking other actions authorized by law.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

9. Administration

(a) House bill.—The House bill requires the Secretary to administer the block grant through an identifiable administrative unit with expertise in maternal and child health that is responsible for coordinating Federal maternal and child health efforts and for providing technical assistance and information to the States and that is authorized to collect, maintain, and disseminate information relating to health status and need of mothers and children.

Senate amendment.—The Senate amendment includes a similar provision, except it does not authorize collection of information relating to health status and needs of mothers and children.

Conference agreement.—The conference agreement includes the Senate provision with modifications specifying that the unit (1) must have expertise in maternal and child health, and (2) must collect information on the health status of mothers and children. The conferees intend that such data will be collected in a manner that avoids duplication.

(b) House bill.—The House bill requires the Secretary to report to Congress by October 1, 1984, on the activities of the States under title V and recommend any appropriate changes in legislation.

Senate amendment.—The Senate amendment includes a similar provision, except it does not establish a deadline and does not require recommendations for appropriate changes.

Conference agreement.—The conference agreement includes the House provision.

10. Effective Date; Transition

(a) House bill.—The House bill provides that the new authorities for special projects, research, and training under the Federal set-aside are to take effect at any point between October 1, 1981, and October 1, 1982, as the Secretary deems appropriate.

Senate amendment.—The Senate amendment provides that the new authorities for special projects, research, and training under the Federal set-aside are to take effect on October 1, 1981.

Conference agreement.—The conference agreement includes the Senate provision.

(b) House bill.—The House bill provides that the new authorities for State block grant allotments are to take effect, at the State's option, no earlier than the first calendar quarter beginning more than 3 months after enactment and not later than October 1, 1982. Authorizes the Secretary to continue making grants under existing programs until a State opts into the block grant.

Senate amendment.—The Senate amendment provides that the new authorities for State block grant allotments are to take effect on October 1, 1981.

Conference agreement.—The conference agreement includes the House provisions with a modification providing for the transition period that begins on October 1, 1981.

11. State Agency

(a) House bill.—The House bill requires that States give assurances that block grant allotments will be administered by the State health agency.

Senate amendment.—The Senate amendment requires that block grant allotments be administered by the State health agency, except for States which on July 1, 1967, used separate agencies to administer their CC programs.

Conference agreement.—The conference agreement includes the Senate provision.

(b) House bill.—No provision.

Senate amendment.—The Senate amendment requires the coordination at the State level between block grant and related programs administered by the Secretary and other Federal programs. Such programs include the medicaid early and periodic screening, diagnosis, and treatment (EPSDT) program, the supplemental food program for mothers, infants, and children administered by the Department of Agriculture, related education programs administered by the Department of Education and other health and developmental disability programs administered by the Secretary, and family planning services authorized under title XX of this Act.

Conference agreement.—Includes the Senate provision with a modification moving the coordination requirement to the statement of assurance.

AUTHORIZATION CAPS

HEALTH PLANNING, HEALTH FACILITIES, HEALTH PROFESSIONS AND NURSE TRAINING

House Bill

The House bill accomplished reductions by reauthorizing appropriations for Health Professions and Nurse Training Programs (titles VII and VIII of the Public Health Service Act). In addition, the House bill reduced the authorization of appropriations for local health planning programs for fiscal year 1982 and made substantive revisions in the existing health planning authorities.

Senate Amendment

Section 1101-1 of the Senate bill S. 1377 provided that the total amount of authorizations to carry out reductions in authorizations of appropriations for Health Planning, Health Facilities, Health Professions and Nurse Training Act shall not exceed \$268,300,000 for the fiscal year ending September 30, 1982 and \$176,715,000 for the fiscal year ending September 30, 1983. The reductions assumed passage of S. 799, The Health Professions Education & Nurse Training Amendments of 1981.

Conference Substitute

The conference substitute conforms to the provisions of the House bill in that it does not provide for a cap on authorizations for programs administered by the Health Resources Administration. The conference agreement for health planning and Health Professions and Nurse Training reauthorization and legislation are contained in other sections of this report.

Senate amendment.—The Senate amendment would, with two exceptions, terminate the program effective October 1, 1982. Under those exceptions, education loans would remain available for use by certain Vietnam-era veterans pursuant to current law: (1) those continuing their full-time training in the first two years after the expiration of the GI Bill delimiting period, and (2) those pursuing flight training courses.

Conference agreement.—The conference agreement incorporates the House termination date with the Senate exceptions.

This provision is estimated to save \$6 million, in outlays only, in fiscal year 1982, \$5 million, in outlays only, in fiscal year 1983, and \$4 million, in outlays only, in fiscal year 1984.

6. *Health care cost recovery*

House bill.—No provision.

Senate amendment.—The Senate amendment would clarify the VA's authority to recover the costs of non-service-connected health care in certain situations in which the veteran would be eligible to have those costs paid by a workers' compensation carrier, an automobile no-fault insurer, or a state that pays health-care costs for victims of crimes of personal violence.

Conference agreement.—The Senate recedes. It is noted that H.R. 3499, as passed by the House on June 2, 1981, contains a very similar provision, and the Veterans' Affairs Committees expect such a provision to be enacted in that bill.

XXI—PROVISIONS RELATING TO MEDICARE AND MEDICAID

1. *Nutritional therapy under end stage renal disease program*

House bill.—The House bill allows coverage under the medicare program for nutritional therapy (when it is used as a means of delaying or substituting for the provision of kidney dialysis) for those beneficiaries who would otherwise qualify for medicare benefits.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision. However, it is the intention of the conferees that the Secretary conduct and promptly complete all studies and experiments required under present law which pertain to the use of, or reimbursement for, nutritional therapy; and, that the Secretary transmit a full and complete report with respect to each study and experiment (containing evidence of the use of statistically valid methods) and including relevant findings and any conclusions or recommendations to the appropriate committees of the Congress not later than January 1, 1983.

2. *Elimination of carryover from previous year of incurred expenses for meeting the part B deductible*

House bill.—The House bill repeals the provision of current law that permits beneficiaries to count expenses incurred in the last quarter of the previous calendar year in determining whether they have met the annual part B deductible for the current year. The provision would apply to the deductible for calendar year 1982 with respect to expenses incurred on or after October 1, 1981.

Senate amendment.—The Senate amendment contains the same provision.

Conference agreement.—The conference agreement includes the House provision.

3. Increase in part B deductible

House bill.—The House bill increases the \$60 part B deductible to \$70 in calendar year 1982. Under the bill, beginning in 1983, the deductible would be increased each year by the same percentage as the annual social security cash benefits increase.

Senate amendment.—The Senate amendment increases the part B deductible to \$75 beginning in calendar year 1982. The Senate amendment did not include an indexing provision.

Conference agreement.—The conference agreement includes the Senate amendment.

4. Changes to part B premium to conform to title II changes

House bill.—The House bill moves the date of the annual part B premium increase from July 1 to October 1, consistent with proposed title II changes which were deleted from the bill by an amendment on the floor of the House.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

5. Increases in the part B premium

House bill.—No provision.

Senate amendment.—The Senate amendment sets the part B premium for both the aged and disabled at an amount equal to 24 percent of program costs for the aged, based on estimates made by the Secretary each December for the 1-year period beginning the following July.

Conference agreement.—The conference agreement does not include the Senate provision.

6. Adjustment in payment for inappropriate hospital services

House bill.—The House bill amends the provision of Public Law 96-499 which provides that, where a beneficiary who no longer requires acute hospital services must remain in the hospital because no long-term care bed is available in the area, the hospital will be reimbursed at a daily rate equal to the adjusted average medicaid skilled nursing facility (SNF) rate in the State for persons needing SNF services, and for purposes of medicaid, at the intermediate care facility (ICF) rate for patients needing ICF services. Public Law 96-499 provided that the reduced level of reimbursement does not apply where a hospital's annual occupancy rate is equal to or greater than 80 percent. The House bill eliminates, for both medicare and medicaid, the occupancy test as a factor in determining reimbursement rates, except for public hospitals. The House bill also provides that no reduction will be made where the Secretary determines that there is no excess of hospital beds in the area in which the hospital is located. The provision is effective for services provided beginning with the month following the date of enactment.

Senate amendment.—The Senate amendment eliminates the occupancy test for both medicare and medicaid. The amendment provides for no reduction in the payment rate where the Secretary determines that there is no excess of hospital beds in either the individual hospital or in the area which could be converted for use in providing long-term care services.

Conference agreement.—The conference agreement generally follows the Senate amendment, but with the House effective date and with a modification which provides that no reduction will be made in the case of a public hospital if: (a) such hospital itself has no excess beds and is part of a public hospital system which, in the aggregate, has no excess of hospital beds; or (b) such hospital, which is not part of a public hospital system in the area, has no excess of hospital beds.

It is the intention of the conference committee that the Secretary, in determining whether there is an excess of hospital beds, should take into account whether skilled nursing facility beds are actually available for patients of public and private hospitals and whether it is feasible for a hospital to convert its beds to long-term care use.

Although the bill eliminates the 80 percent occupancy test, the conference committee does not intend to preclude its use as a measure of whether excess hospital beds exist; instead, the Secretary would have flexibility to take into account size of hospitals and other factors in determining whether there are excess beds.

The conference committee intends that determinations regarding excess beds and reductions in reimbursement should be made on the basis of criteria promulgated in advance, and at intervals and with data requirements so as not to impose major administrative burdens on hospitals.

7. Incentive reimbursement rate for renal dialysis services

House bill.—The House bill requires the Secretary of Health and Human Services to prescribe in regulation a method (or methods) for determining the amounts of payments to be made for renal dialysis services incorporating in a single reimbursement rate structure, reimbursement for dialysis treatments in a facility and dialysis treatments in the home setting. The House bill requires the method promulgated by the Secretary to provide for a prospectively set rate (or rates) for each mode of care, and to be established on the basis of a single composite weighted formula taking into account the proportions of patients dialyzing in a facility and those dialyzing at home. The House bill further permits the Secretary to promulgate an alternative rate setting method if he determines, after detailed analysis, that an alternative rate setting method would provide greater incentives for increased use of lower-cost home dialysis than would a single composite rate.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill with modifications. Separate composite weighted formulae would be calculated for hospital-based and for other renal dialysis facilities. Both formulae would continue to take into account the proportions of patients dialyzing in a facility and those dialyzing at home and the relative costs of providing services in such settings.

In addition, if the Secretary determines, after detailed analysis, that another method (or methods) of determining prospectively the amounts of payments to be made for dialysis services would more effectively encourage the more efficient delivery of dialysis services and would provide greater incentives for increased use of less costly home dialysis than the dual composite weighted formula, the Secretary may use such other method, (which must differentiate between hospital-based facilities and other renal dialysis facilities). The payment method adopted must provide for exceptions for unusual circumstances (including the special circumstances of sole facilities in isolated, rural areas).

The conference committee expects that an area wage adjustment will be used in determining the reimbursement rates.

8. Limits on reimbursement to home health agencies

House bill.—The House bill reduces from the 80th to the 75th percentile the medicare reimbursement limits currently applied to home health agency costs. Such limits, established by regulation, are set at the 80th percentile of average per visit costs, calculated by type of service but applied as a single aggregate limit. The House bill permits use of an alternative methodology providing the resulting limits are no less stringent than those that would be achieved using the 75th percentile under the current methodology.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provision with a clarification to permit continuation of the Secretary's authority to grant exemptions and exceptions from the reimbursement limits. Although home health agency reimbursement limits are currently being imposed as a single aggregate limit, the conference committee urges the Secretary, as soon as feasible, to begin to impose the limits by type of service.

The provision is effective for cost reporting periods of home health agencies ending after September 30, 1981, but the lower limits are applicable only in proportion to that portion of the reporting period occurring after that date. For the sake of clarity, the following example is given:

A home health agency has a cost reporting period ending December 31, 1981 with aggregate medicare costs of \$175,000. The aggregate cost limit for the period beginning January 1, 1981 was \$160,000 and the aggregate limit under the bill was \$150,000. The disallowance in this situation would be \$17,500. This is computed as follows: The disallowance under the old limit (\$15,000) plus the proportionate share of the disallowance resulting from the application of the new limit. The proportionate share of the disallowance resulting from the application of the new limit is \$25,000 (new limit disallowance) minus \$15,000 (old limit disallowance) multiplied by the portion of the cost reporting period after September 30, 1981 (25 percent). Thus the total disallowance is \$17,500 (\$15,000 + \$2,500).

9. Civil money penalties

A. House bill.—The House bill authorizes the Secretary to impose a civil money penalty of up to \$2,000 for fraudulent claims under medicare or medicaid, to impose an assessment of twice the amount of the fraudulent claim, and to bar from participation per-

sons determined to have filed a fraudulent claim. There would be a right to written notice and an opportunity for a hearing on the record.

Senate amendment.—The Senate amendment includes a similar provision.

Conference agreement.—The conference agreement includes the Energy and Commerce Committee language of the House provision. The conference agreement includes a technical amendment deleting language in section 1128(a)(1) of the Social Security Act to conform the provision to that in section 1862(d) of the Act.

B. House bill.—The Ways and Means Committee provision of the House bill provides that a person would be entitled to a trial *de novo* in any case in which the penalties imposed exceeded \$15,000 for services during a 2-year period or where the person was barred from participation for more than 5 years. The Energy and Commerce provision of the House bill provides for a trial *de novo* for penalties of \$25,000 in a 1-year period; no trial *de novo* would be provided when an individual was barred from participation.

Senate amendment.—No provision.

Conference agreement. The conference agreement does not include either of the House provisions.

C. House bill.—The House bill provides that no penalties will be assessed nor payment prohibited until all administrative and judicial remedies have been exhausted.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provision with an amendment deleting the reference to exhaustion of judicial remedies and providing that no penalties will be assessed nor payment prohibited until all administrative remedies have been exhausted.

10. *Utilization guidelines for the provision of home health services*

House bill.—The House bill requires the Secretary of Health and Human Services to establish and provide for the implementation of utilization guidelines for home health services by October 1, 1981. The bill requires the Secretary to issue instructions to medicare intermediaries for a program of post-payment coverage review of submitted claims, on a sample basis, to monitor compliance with the medical necessity and other requirements of present law for medicare coverage of home health services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

11. *Technical corrections for errors made by the "Medicare and Medicaid Amendments of 1980"*

House bill.—The House bill restores a provision that was erroneously deleted by Public Law 96-499 (the provision limited part B reimbursement to the lower of the provider's customary charge or the reasonable cost of the covered services). The House bill makes several other minor technical and clerical corrections.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision, with a technical correction.

12. *Statutory guidelines for implementing AFDC home health aide demonstration*

House bill.—The House bill requires the Secretary to establish by October 1, 1981, such guidelines and regulations as are necessary to assure that agreements with the States for the conduct of demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides, as provided for by Public Law 96-499, are entered into by January 1, 1982. The House bill requires the Secretary to report to Congress during January 1982 on the current and anticipated progress of the projects.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision. It is the intention of the conference committee that the Secretary will speed up the implementation of the provision of Public Law 96-499 and enter into as many agreements as possible subject to the 12 State limit.

13. *Professional standards review organizations*

A. *House bill.*—The House bill directs the Secretary to assess, not later than September 30, 1981, the relative performance of each Professional Standards Review Organization (PSRO) in: (1) monitoring the quality of patient care, (2) reducing unnecessary utilization, and (3) managing its activities effectively. The bill authorizes the Secretary, based on this assessment, to terminate up to one-half of current PSROs by the end of fiscal year 1982.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with an amendment to limit the number of PSROs which the Secretary can terminate by the end of fiscal year 1982 to 30 percent of the current PSROs.

B. *House bill.*—The House bill provides States the option of contracting with PSROs for medicaid review and provides for a 75 percent Federal matching rate for the costs of review. (Currently, the Secretary of HHS contracts with PSROs to conduct medicare and medicaid review with the Federal government financing 100 percent of the cost.)

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

C. *House bill.*—The Energy and Commerce Committee provision of the House bill requires the Secretary, in conjunction with termination of ineffective PSROs, to consolidate PSRO areas so that there would be no more than five PSROs in any State.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

D. *House bill.*—The Ways and Means Committee provision of the House bill repeals the PSRO program effective September 30, 1983.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

E. *House bill.*—The House bill permits, instead of requiring, as under current law, PSROs to delegate review to hospitals where the hospital demonstrates its effectiveness in conducting such review.

Senate amendment.—No provision.

Conference agreement. The conference agreement includes the House provision.

F. House bill.—The House bill repeals the provision of current law which authorizes the Secretary to require review of ancillary, ambulatory, and long-term care services only where the cost effectiveness of such review has already been demonstrated. The House bill thereby allows the Secretary to permit PSROs to review such services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

14. Repeal of utilization review committee requirement

House bill.—The House bill repeals the statutory requirement for utilization review committees in institutions for medicare and medicaid.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

15. Medicare as secondary payor to Federal Employees Health Benefits (FEHB) program

House bill.—The Ways and Means provision of the House bill provides that, for persons age 65 and over, who are entitled to coverage under both medicare part B and FEHB, medicare would become the secondary payor. Under the provision, medicare part A would become the secondary payor to the FEHB program only with respect to those persons reaching age 65 on or after January 1, 1982. (The Post Office and Civil Service Committee provision calls for maintaining the present law relationship between FEHB and medicare.)

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include either of the House provisions.

16. Medicare hospital reimbursement experiments

House bill.—The House bill repeals the provision of current law limiting the number of statewide medicare hospital reimbursement demonstration projects to six.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision

17. Payments to promote closing and conversion of under-utilized facilities

House bill.—The House bill permits medicaid matching (other than in medically underserved areas) for cost associated with eliminating excess bed capacity, discontinuing and underutilized service for which there are adequate alternative resources in the area, or substituting for the underutilized service some other service which is needed in the area. The House bill provides that such matching would be available only to the extent that such expenditures are consistent with a State statutory program for reduction of the number of hospital beds (where there is such a program) and sec-

only that fair and equitable arrangements have been made to protect the interests of employees affected by any discontinuance of hospital services. The House bill further provides that Secretarial approval would be required to the extent payments exceeded the medicare reasonable cost level.

Senate amendment.—The Senate amendment provides for reimbursement under titles V, XVIII, and XIX for capital-related and increased operating costs associated with closing or conversion to approved use, of underutilized beds or services in hospitals. The Senate amendment establishes a Hospital Transitional Allowance Board to advise the Secretary regarding such payments and provides that the Secretary's final determination with respect to a hospital's request for a transitional allowance is not subject to judicial review. The Senate amendment further provides that, prior to January, 1, 1984, transitional allowance payments could be made to no more than 50 hospitals; and requires the Secretary to report to Congress by January 1, 1983 on this program.

Conference agreement.—The conference agreement follows the Senate amendment with modifications. The Conference agreement eliminates the provision establishing a Hospital Transitional Allowance Board and provides the Secretary of HHS with authority to make transitional allowance payments. A transitional allowance may not be paid unless the proposed closing or conversion is consistent with the findings on an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State. Further, the agreement deletes the provision specifying that the Secretary's final determination with respect to a hospital's request for a transitional allowance is not subject to judicial review. The provision permitting transition allowance payments under title V would be deleted. A State may, at its option, include as a cost in hospital reimbursement under medicaid (title XI) periodic expenditures made to reflect transition allowances under medicare (title XV.)

It is the intention of the conference committee that transitional allowance payments for closure will not be made to hospitals located in medically underserved areas. It is also the intention of conference committee that, as a condition for granting a transitional allowance, the Secretary is satisfied that fair and equitable arrangements have been made to protect, to the extent feasible, the rights and benefits of employees affected by any discontinuance of hospital services, with respect to their employment, as provided for under contractual arrangements with the hospital.

18. *Limitation on medicare and medicaid payments for certain drugs*

House bill.—The House bill prohibits payments under medicare part B and medicaid for those prescription drugs which were approved prior to the 1962 amendments to the Federal Food, Drug and Cosmetic Act and which the Secretary, or his delegate, determines to be less than effective in use. The House bill also terminates reimbursement for all identical, related, or similar drug products which are not medically necessary by publishing a notice of an opportunity for hearing under section 505(e) of the Federal Food, Drug and Cosmetic Act.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

19. Withholding of payments for certain medicaid providers

House bill.—The House bill authorizes the Secretary to offset, from reimbursements due to medicare providers, overpayments made to them under medicaid in cases where the provider has terminated or substantially reduced his participation in medicaid. The House bill provides that State medicaid agencies would be reimbursed from amounts recovered.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

20. Elimination of need for occupational therapy as a basis for entitlement to home health services

House bill.—No provision.

Senate amendment.—The Senate amendment eliminates occupational therapy as a qualifying criterion for home health benefits.

Conference agreement.—The conference agreement follows the senate amendment with a modification which provides that where an individual has otherwise qualified for home health benefits (i.e., on the basis of his need for skilled nursing care, speech therapy or physical therapy), his eligibility for home health services may be extended solely on the basis of his continuing need for occupational therapy.

21. Elimination of unlimited open enrollment; restrictions on new State buy-in agreements

A. House bill.—No provisions.

Senate amendment.—The Senate amendment repeals the provision of Public Law 96-499 which provided for continuous open enrollment under medicare part B and reinstitutes the annual January-March enrollment period.

Conference agreement.—The conference agreement includes the Senate provision.

B. House bill.—No provisions.

Senate amendment.—The Senate amendment repeals the provision of Public Law 96-499 which allowed States, during calendar year 1981, to enter into or modify their medicare part B buy-in agreements on behalf of their medicaid eligibles.

Conference agreement.—The conference agreement does not include the Senate provision.

22. Pneumococcal vaccine

House bill.—No provision.

Senate amendment.—The Senate amendment repeals the pneumococcal vaccine coverage under medicare as authorized by Public Law 96-611. The Senate amendment provides that vouchers would be made available on a one-time basis to non-institutionalized recipients of Federal Supplemental Security Income (SSI) payments who are aged 65 and older. The value of the voucher would be the medicaid allowable charge by, or cost to, a physician or other provider in administering pneumococcal vaccine (including the cost of the vaccine) but not to exceed \$10. In addition, the Senate amend-

ment provides that Federal matching would be made available on a permanent basis under title XIX, equal to 100 percent of the reasonable cost incurred, not to exceed \$10 per vaccination, for pneumococcal vaccine provided to any individual age 65 or older who is eligible under the State medicaid plan or who is receiving Supplemental Security Income benefits.

Conference agreement.—The conference agreement does not include the Senate provision. The conferees intend that a one-time announcement informing medicare beneficiaries of the pneumococcal vaccine benefit be included in a regular mailing of social security checks.

23. Criteria for determining reasonable charge for physician's services

House bill.—No provision.

Senate amendment.—The Senate amendment requires the calculation under medicare (in any State with more than one locality) of statewide median charges in addition to prevailing charges in the locality. The amendment provides that to the extent that any prevailing charge in a locality is more than one-third higher than the statewide median charge for a given service, such prevailing charge would not be automatically increased each year. The Senate amendment also permits new physicians in localities which are designated by the Secretary as physician-shortage areas to establish their customary charges at the "prevailing" level (i.e., generally at the 75th rather than the 50th percentile) of customary charges in the locality.

Conference agreement.—The conference agreement does not include the Senate provision.

24. Limitation on reasonable charge for outpatient services

House bill.—No provision.

Senate amendment.—The Senate amendment requires the Secretary to establish by regulation limitations on costs or charges that will be considered reasonable for outpatient services provided by hospitals, community health centers or clinics and by physicians utilizing these facilities. The Senate bill provides that limitations are to be reasonably related to the reasonable charges in the same area for similar services provided in physicians' offices.

Conference agreement.—The conference agreement follows the Senate provision with the following modifications: (A) the limitations will not apply with respect to *bona fide* hospital emergency room services; (B) actual charges, not medicare-determined reasonable charges of physicians, will be used in developing the limitations; (C) the Secretary is required to establish such limitations only to the extent feasible; and (D) exceptions may be provided in areas where physician services are not generally available.

25. Medicare payments secondary in cases of end-stage renal disease

House bill.—No provision.

Senate amendment.—The Senate amendment provides that medicare would become the secondary payor for the first 12 months after an individual has been determined to be eligible for end-stage renal benefits under the medicare program, but only where such individual has private health insurance coverage, and provided

that the individual is under age 65 and is eligible as a renal disease beneficiary. The Senate amendment provides that medicare would become the primary payor beginning with the thirteenth month following the month in which entitlement to end-stage renal benefits is established. The Senate amendment would also deny, as a business expense deduction under the tax code, the expenses paid or incurred by an employer for a health plan, if such plan contains a discriminatory provision that reduces or denies payment of benefits for renal patients.

Conference agreement.—The conference agreement follows the Senate provision with modifications.

The conference agreement would require, in the case of renal disease beneficiaries, that medicare would pay for the beneficiary's care in the usual manner and then obtain reimbursement from the beneficiary's private group health insurance plan for the items and services covered by that plan until such time as the Secretary determines that the beneficiary's plan has begun to make payments promptly or will be able to make such payments as promptly as would be the case if medicare were making the payment. It is the conferees' intent, in providing for such administrative discretion with respect to the point at which medicare need no longer be the first payor, that the Secretary's decision will be made in recognition of the need to assure prompt payment, avoid inconvenience to the patient, and encourage home dialysis. The payment arrangements contemplated by the conferees are intended to minimize patient anxiety about the source of promptness of payment and to avoid delays in reimbursement for expenses incurred in connection with the use of renal equipment, supplies or services. Under the conference agreement, the secondary payor arrangement would apply only where the private coverage of the medicare beneficiary is through an employer group health plan.

The conference committee is also concerned about potential job discrimination resulting from this provision, and directs the Secretary to investigate promptly complaints of this nature, and report its findings to the Congress periodically.

PROVISIONS RELATING TO MEDICARE

1. Elimination of coverage of alcohol detoxification facility services

House bill.—The House bill repeals the provision in present law under which reimbursement for inpatient alcohol detoxification services in freestanding facilities is authorized. The House bill also repeals the requirement that the Secretary conduct studies and demonstration projects related to alcohol and drug detoxification and rehabilitation. The provision in the House bill regarding reimbursement would apply to inpatient stays in detoxification facilities beginning on or after the tenth day after the date of enactment.

Senate amendment.—The Senate amendment contains the same provisions as the House bill, except for the effective date. Reimbursement could not be made with respect to services furnished after the month of enactment.

Conference agreement.—The conference agreement includes the House provision.

2. *\$1 copayment for each of first 60 days in hospital*

House bill.—The House bill imposes a \$1 copayment on medicare inpatients for each of the first 60 days of care during a spell of illness.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

3. *Making part A coinsurance current with the year in which services are furnished*

House bill.—The House bill bases the part A coinsurance on the current year's deductible, rather than the deductible in effect at the time the beneficiary's spell of illness began.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

4. *Making part A coinsurance and deductible more current*

House bill.—The House bill makes the part A deductible and coinsurance more current by adding \$5 to the base figure of \$40 in the formula that is used in the annual determination of the inpatient hospital deductible. The provision would apply with respect to inpatient hospital services furnished in calendar years beginning with 1982.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision

5. *Offset of interest and other income on funded depreciation*

House bill.—The House bill requires the offset of interest and other income earned on funded depreciation against allowable interest expense reimbursable under medicare.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

6. *Limits on reimbursement to hospitals*

House bill.—The House bill lowers medicare's reimbursement limits on hospital inpatient general routine operating costs from 112 percent to 108 percent of the mean costs of each comparable group of hospitals under the methodology now used to make such determinations, or to some other no less stringent limit.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with a modification that continues the Secretary's current authority to permit exemptions (e.g. for a sole community provider) and exceptions from the limits.

The provision is effective for cost reporting periods of hospitals ending after September 30, 1981, but the lower limits are applicable only in proportion to that portion of the reporting period occurring after that date. For the sake of clarity, the following example is given:

A hospital has a cost reporting period ending March 31, 1982 with a per diem routine operating cost of \$160. The limit effective for the cost reporting period beginning April 1, 1981 was \$150 and

the limit issued pursuant to the bill was \$140. The disallowance under the old limit was \$100,000 and under the new limit \$200,000. The actual disallowance in this case would be \$150,000 which is computed as follows: Disallowance under old limit (\$100,000) plus the proportionate share of the disallowance resulting from application of the new limit. The proportionate share of the disallowance resulting from the application of the new limit is \$200,000 (new limit disallowance) minus \$100,000 (old limit disallowance) multiplied by portion of cost reporting period after September 30, 1981 (50 percent) equals \$50,000. Thus, the total disallowance is \$150,000 (\$100,000 + \$50,000).

7. Repeal of statutory time limitation on agreements with skilled nursing facilities

House bill.—The House bill repeals the provision in present law that requires skilled nursing facility provider agreements to be renewed on an annual basis.

Senate amendment.—Same provision.

Conference agreement.—The conference agreement follows the House provision.

8. Repeal of temporary delay in periodic interim payments (PIP)

House bill.—The House bill repeals the provision in Public Law 96-499 relating to a temporary delay in periodic interim payments.

Senate amendment.—Same provision.

Conference agreement.—The conference agreement includes the House provision.

9. Reduction in the 8½ percent routine nursing salary cost differential

House bill.—No provision.

Senate amendment.—The Senate amendment provides for a reduction in the routine nursing salary cost differential to 4.5 percent, and requires the Comptroller General to conduct a study to determine the extent to which higher payments are justified and report back to Congress.

Conference agreement.—The conference agreement follows the Senate amendment, except that the reduction in the routine nursing salary cost differential would be to 5 percent.

10. Elimination of certain dental coverage

House bill.—No provision.

Senate amendment.—The Senate amendment repeals the provision added by Public Law 96-499 which authorized hospitalization coverage under medicare where the severity of the non-covered dental procedure warrants inpatient care.

Conference agreement.—The conference agreement does not include the Senate provision.

PROVISION RELATING TO MEDICAID

1. Reduction in medicaid payments to the States

House bill.—The House bill provides that Federal matching payments to States would be reduced by 3 percent in FY 1982, 2 percent in FY 1983, and 1 percent in FY 1984, from the amounts to

which States would otherwise be entitled. The statutory matching formula would not be altered. Under this temporary pro rata reduction in Federal payments, a State would determine the total Federal payment due for Medicaid services and administrative costs by applying current matching rates. This total dollar amount would then be reduced by 3 percent, 2 percent, or 1 percent in the applicable year. A State could lower the amount of its reduction by one third for each of the following: (a) operating a qualified hospital cost review program; (b) sustaining an unemployment rate exceeding 150 percent of the national average; or (c) demonstrating recoveries from fraud and abuse and third party liability activities equal to 1 percent of Federal payments.

The House bill increases the ceiling on Federal matching payments in fiscal year 1982 for Puerto Rico (to \$35 million), the Virgin Islands (to \$1.5 million), and Guam (to \$1.4 million). It establishes ceiling beginning in fiscal year 1982 for the Northern Mariana Islands (\$350,000), and authorizes the participation of the following territories and establishes a ceiling for each: American Samoa (\$350,000), and Trust Territory of the Pacific Islands (\$1.4 million).

Senate bill.—The Senate bill provides that Federal matching payments to each state would be capped in FY 1982 and each succeeding fiscal year. For FY 1982, the cap on Federal payments would be set at 9 percent above estimated outlays for FY 1981. For FY 1983 and thereafter, Federal payments would be allowed to rise at the rate of inflation for that fiscal year as measured by the GNP Deflator. The bill excludes the following items from a cap: (a) Medicaid Management Information Systems; (b) State Medicaid Fraud Control Units; (c) payments to Indian Health Service Facilities; (d) interest payment owed to States on disputed claims; (e) payments owed to States for prior year claims; and (f) payments for pneumococcal vaccine for the aged. The bill also establishes a Medical Assistance Commission to report to the President and Congress on the validity and equity of adjustments in Federal matching payments under the cap to reflect factors out of a State's control, including population shifts, demographic changes, unemployment rates, eligibility and benefits policies, and changes in economic conditions. The bill also increases the ceiling in fiscal year 1982 for Puerto Rico (to \$45 million).

Conference agreement.—The conference agreement follows the House provision with modifications. Under the conference agreement, the amount of Federal matching payments to which a State is otherwise entitled is to be reduced by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State could lower the amount of its reduction by one percentage point for each of the following: (a) operating a qualified hospital cost review program, (b) sustaining an unemployment rate exceeding 150 percent of the national average; and (c) demonstrating recoveries from fraud and abuse and, with respect to FY 82, third party recoveries equal to 1 percent of Federal payments. A State is entitled to a dollar for dollar offset in its reductions if total Federal Medicaid expenditures in a year fall below a specified target amount. In no case can the amounts recovered by a State through this means exceed the total amount withheld. In 1982, the target amount is equal to 109 percent of the State's estimates for

FY 81 which were received by the Secretary prior to April 1, 1981. In 1983 and 1984 the target amounts are equal to the 1982 target amount increased or decreased by the same percentage as the increase or decrease in the index of the medical care expenditure component of the consumer price index over the same period.

For purposes of calculating whether a State has met its target amount in FY 84, its federal medical assistance percentage for FY 84 shall be deemed to be equal to such percentage for FY 83. This is done to assure that no rewards would be given to a State simply because of a change in the share of their program the Federal government pays for. The conference agreement excludes the following items from the determination of whether a State spends less than its target amount for a year: (a) adjustments with respect to prior year claims; (b) interest paid on disallowances for prior years; and (c) any offset payments the State has received for spending less than its target amount in the previous year, and (d) any of the reductions in the Federal funds a State receives that are imposed by this provision.

The conference agreement provides that no percentage reduction may be made for any quarter unless, as of the first day of the quarter, the Secretary has promulgated regulations pertaining to modified requirements for medically needy programs, and modifications in requirements for hospital reimbursement as provided for in this conference agreement and SNF/ICF reimbursement as provided for in the 1980 reconciliation bill. The conference committee expects that while regulations will initially be issued on an interim basis, the Secretary will move as rapidly as possible to issue them in final form, consistent with the requirements for review, comment, and the hearing process.

The conferees note that this approach to reducing Federal Medicaid expenditures does not preclude Arizona, which does not currently have Medicaid program, from establishing one. The reductions and bonuses are applicable to the existing programs in the 49 States and the District of Columbia.

The territories are excluded from the reduction and offset provisions. The territories are subject to the following limitations on Federal expenditures: Puerto Rico—\$45 million; Virgin Islands—\$1.5 million, Guam—\$1.4 million, and the Northern Mariana Islands—\$350,000.

The conference agreement provides that a qualified hospital cost review program is one which has been established by statute, is operated directly by a State, applies to substantially all non-Federal hospitals, and reviews all non-Medicare inpatient revenues or expenses or at least 75 percent of all revenues or expenses including those arising under Medicare. All qualifying programs must assure the Secretary that each entity which pays for hospital services, employees, and patients (including the Medicare and Medicaid programs) is provided substantially equal treatment with regard to the costs or rates approved by the State agency in each hospital. To be approved the State must show that the annual rate of increase in aggregate hospital inpatient costs per capita or per admission have risen at least 2 percentage points less (using a one, two, or three year base) than the rate of inflation in all States without qualifying programs. The increase in inpatient expenditures per capita is generally considered to be the most suitable measure to

judge effectiveness because it recognizes the effects of population changes on hospital costs and it produces incentives to the cost review programs to discourage excess hospital use as well as to contain unit costs. However, this measure could affect adversely states experiencing a changing pattern of persons crossing State borders to obtain hospital care or States with an acceleration of population decline. For this reason, the conferees expect that States will be permitted to demonstrate effectiveness using data on inpatient hospital expenses per case.

The conference committee notes that some State programs do not actually process reports from hospitals with projected cost increases below an announced target. The revenues or expenses of such hospitals should be considered by the Secretary as reviewed for the purposes of determining if a program reviews sufficient revenues or expenses to be a qualified program.

Further, the conference committee further notes that the test set forth to determine a qualified hospital cost review program is not meant to preclude State or substate experiments with approved waivers.

The conferees understand and intend that the States which have qualified hospital cost review programs are Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington.

2. Federal Medical Assistance Percentage Formula

A. House bill.—No provision.

Senate amendment.—The Senate bill lowers the minimum Federal share of State's payments for Medicaid from 50 percent to 40 percent, effective for State expenditures made on or after October 1, 1981.

Conference agreement.—The Conference agreement does not include the Senate provision.

B. House bill.—The House bill requires the Comptroller General, in consultation with the Advisory Committee on Intergovernmental Relations, to study the existing matching formula and report to Congress by March 31, 1982, with recommended revisions.

Senate amendment.—The Senate amendment establishes a Medical Assistance Commission to report to the President and Congress on the validity and equity of adjustments in Federal matching payments under the cap to reflect factors out of State's control, including population shifts, demographic changes, unemployment rates, eligibility and benefit policies, and changes in economic conditions.

Conference agreement.—The conference agreement follows the House provision with an amendment. The conference agreement provides for a study by the General Accounting Office of the Federal medical assistance percentage. The study shall include the feasibility and consequences of revising the formula to take into account the relevant factors bearing on an equitable distribution of Federal funds. The study should also include an analysis of the impact of appropriate modification of the target rate for a State if it experiences substantial changes in composition or characteristics of its population (e.g., increased unemployment or aging of the population) which are out of the ordinary and effectively not within the control of the State.

3. Hospital reimbursement rate determination

A. House bill.—The House bill repeals the provision of current law which requires State Medicaid programs to pay for inpatient hospital services on a reasonable cost basis as defined under medicare except where the Secretary has approved an alternative reimbursement method. The House bill requires that State payments for inpatient hospital services (a) be “reasonable and necessary to the efficient and economical delivery of services,” (b) take into account the special costs of hospitals whose patients are disproportionately Medicaid eligible or without third party coverage, and (c) are sufficient to assure that Medicaid patients have reasonable access to services of adequate quality.

Senate amendment.—The Senate amendment also repeals the current law provision. It requires that State payments for inpatient hospital services be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities” in order to meet applicable laws and quality and safety standards. The Senate amendment provides that the amount paid cannot, in the aggregate, exceed the amount determined to be reasonable under Medicare.

Conference agreement.—The conference agreement follows the Senate amendment with a modification providing that States, in developing their payment rates, take into account the situation of hospitals which serve a disproportionate number of account the atypical costs incurred by hospitals which serve a disproportionate number of low income patients. The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates. Further, the conferees intend that State hospital reimbursement policies should meet the costs that must be incurred by efficiently-administered hospitals in providing covered care and services to medicaid eligibles as well as the costs required to provide care in conformity with State and Federal requirements. It also is recognized that States may limit increases to the increases that result from price increases for goods and services purchased by hospitals, as measured by such indices as the national hospital input price index, for example.

B. House bill.—The House bill requires States as of October 1, 1983, to use a prospective payment system for inpatient hospital services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

C. House bill.—The House bill requires the Secretary to develop, by March 31, 1982, a prospective payment methodology for inpatient hospital services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provision with a modification which requires the Secretary to develop a model prospective payment methodology for inpatient hospital services which could be used both under the Medicare and medicaid programs. At least one model developed should include the use of case-mix groupings for the classification of hospitals. The

conference agreement further provides that the Secretary shall report on the progress in developing his system by July 1, 1982.

D. House bill.—No provision.

Senate amendment.—The Senate amendment requires that States provide assurances satisfactory to the Secretary, for the filing of uniform cost reports by each hospital and periodic audits by the State of such reports.

Conference agreement.—The conference agreement includes the Senate amendment.

4. *Competitive arrangements for payment for laboratory services, medical devices, and drugs*

House bill.—The House bill amends the current freedom of choice requirements to authorize States to purchase laboratory services, medical devices, or drugs through a competitive bidding process or otherwise in order for such arrangements to be approved, the Secretary must find that adequate services, devices, or drugs will be available; in the case of laboratory services, that the laboratories selected meet applicable quality standards and do no more than 75 percent of their business with Medicaid and medicare; and that the charges to Medicaid for devices, drugs, and laboratory services are at the lowest rate charged in the area.

Senate bill.—No similar provision (See Item No. 5).

Conference Agreement.—The conference agreement follows the House provision with an amendment which deletes the provision that specifies that competitive or similar arrangements must assure that the prices charged the program would not exceed the lowest amount generally charged to others for similar items, and which eliminates drugs from the services which can be provided under these competitive bidding arrangements. (Note: See Item No. 5 for a discussion of the "freedom-of-choice" provision and for provisions relating to cost effective arrangements for drugs).

5. *Waiver of Medicaid requirements*

House bill.—The House bill authorizes the Secretary to waive any Federal Medicaid requirements necessary to enable a State to (a) implement a primary care case management system, (b) lock individuals who overutilize services into particular providers, (c) limit the participation of providers who abuse the program, and (d) allow a locality to offer competing health plans to eligible persons. The bill requires the Secretary to act upon a State request for a waiver within 90 days of receiving the request and information necessary to make a determination. The Secretary is authorized to waive any Federal Medicaid requirements necessary to enable a State to share with program eligibles through direct payments or additional services the savings resulting from the use of cost-effective methods of health care delivery. The bill terminates the Secretary's waiver authority on September 30, 1985, and requires Secretary to report to Congress on waivers granted.

Senate amendment.—The Senate amendment repeals the freedom of choice provision of current law. It authorizes States to restrict Medicaid eligibles to obtain services through "cost-effective arrangements". It requires that such arrangements (a) provide for reasonable payment and (b) assure that Medicaid eligibles have reasonable access to covered services.

Conference agreement.—The conference agreement amends current law to permit a State to: (a) require individuals who overutilize services to use particular providers, and (b) limit the participation of providers, which the State has found (after notice and opportunity for a hearing in accordance with State administrative practices) to have, in a significant number or proportion of cases, abused the program. A restriction is permitted provided individuals eligible for a service have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

The conference agreement authorizes the Secretary to waive certain requirements of law to achieve certain program purposes provided he finds them to be cost effective, efficient, and not inconsistent with program intent. Under the waiver authority the Secretary to the extent necessary to implement a case management or specialty physician services arrangement is authorized to restrict the provider from or through whom individuals can obtain primary care services (other than under emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality. Under the waiver authority, a locality is permitted to act as a central broker in assisting individuals in selecting among competing health plans. Further, the Secretary may waive requirements necessary to enable a State to share with recipients the savings resulting from use of more cost-effective service arrangements.

The conference agreement also provides that the Secretary may approve under the waiver authority, State restrictions on providers or practitioners from or through whom an individual may obtain services (other than emergency services and including drugs) provided: (a) such providers or practitioners must accept and comply with the reimbursement quality and utilization standards under the State plan; (b) such restrictions are consistent with access, quality, and efficient and economic provision of care and services; and (c) such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiencies in providing services. The Secretary shall for purposes of evaluating waiver requests, develop performance standards for cost effective provision of services, based on such criterion as length-of-stay or cost per admission.

The conference agreement requires the Secretary to approve waiver requests within 90 days of submission. The conferees have approved a time limit in order that the States may implement program changes on a timely basis. The conferees intend that in cases where the Secretary has received incomplete information, it is expected he will deny such request until it meets standards outlined in regulations.

The conferees recognize the Secretary may begin granting waivers under this section shortly after enactment. They intend, however, that regulations be issued as soon as possible, consistent with hearing and comment requirements, so that States will receive guidance concerning the standards for waiver requests the Secretary will apply.

6. *Elimination of EPSDT penalty*

House bill.—The House bill repeals the current law provision which subjects States to a 1 percent reduction in Federal matching payments under their Aid to Families with Dependent Children program (AFDC) if they fail to meet certain performance standards for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services under Medicaid. The House bill further incorporates the EPSDT standards under title XIX.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision. It is the intention of the conference committee that States should continue to develop fully effective EPSDT programs. However, the current EPSDT reporting requirements, which entail a large volume of paperwork, should be significantly streamlined.

7. *Repeal of required Medicaid coverage for individuals aged 18-20*

A. House bill.—The House bill repeals the requirement that States provide Medicaid coverage to persons under 21 who would be eligible for AFDC if attending school and instead makes coverage of such individuals optional.

Senate amendment.—Similar provision.

Conference agreement.—The conference agreement includes the Senate provision.

B. House bill.—No provision.

Senate amendment.—The Senate amendment allows States which choose to cover children under Medicaid who would be eligible for AFDC except for a school attendance requirement to limit such coverage to children under 21, 20, 19, or 18, or any reasonable category of such children.

Conference agreement.—The conference agreement includes the Senate amendment.

8. *Removal of medicare reasonable charge limitation*

House bill.—The House bill repeals the requirements that State Medicaid payments for physicians' services and certain medical supplies and laboratory services cannot exceed reasonable charge levels established under Medicare.

Senate amendment.—The Senate amendment modifies the House bill to provide that the existing Medicare limit must be applied in the aggregate.

Conference agreement.—The conference agreement includes the House provision.

9. *Options for the provision of home and community-based care and requirement of preadmission screening for long-term care patients*

A. House bill.—The House bill authorizes States, subject to approval by the Secretary, to provide Medicaid coverage for a range of home and community-based services pursuant to an individual plan of care to persons determined through a comprehensive assessment, to be in need of long-term skilled nursing facility (SNF) or intermediate care facility (ICF) services.

Senate amendment.—The Senate amendment authorizes the Secretary to waive Federal requirements to enable a State to cover

personal care services and other services pursuant to an individual plan of care to persons who would otherwise require institutionalization.

Conference Agreement.—The conference agreement includes the Senate provision with the following modifications: (1) States must determine that individuals would otherwise need institutional care. Currently, certification by a physician is often all that is required for nursing home placement. The conferees recognize that many medical and non-medical factors bear on a decision to seek long-term care, and thus all factors relating to the need for institutionalization should be taken into account in the evaluation of such need.

(2) States must determine that it is reasonable to provide individuals with alternative services, available at their choice, pursuant to a plan of care. While it is expected that the existence of alternatives will encourage the acceptance of community care, the conferees emphasize that the integrity of patient choice should be preserved. The determination of which long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by an evaluation, and not short-term cost savings. While the conferees anticipate that the provision of community-based care will have a long range and significant impact on the size of States' Medicaid budgets, they do not believe that States should make decisions regarding the feasibility of community-based care on the basis of whether or not such arrangements will produce short-term cost savings. 3) The State must provide for the formulation of a written plan of care for persons provided waived services, and must determine that the making available of alternative services to such persons would not result in overall expenditures in excess of those which would be incurred if that person were institutionalized. The cost of physician visits, hospitalization, prescription drugs, etc. that the individual would have received would be included in the State's estimates of Medicaid expenditures in addition to the cost of SNF or ICF care for that individual. 4) The following services may be included in the State program: nursing, medical supplies and equipment, physical and occupational therapy, and speech pathology and audiology, now authorized. Additional services which may be included are homemaker/home health aide personal care services; adult day health; habilitation; case management; respite care; and other services requested by the State and approved by the Secretary. Homemaker and adult day health care are defined in Title XX of the Social Security Act. Habilitation encompasses both health and social services needed to insure optimal functioning of the mentally retarded and the developmentally disabled. Respite care services are given to an individual unable to care for him/herself and which are provided on a short-term basis to such an individual because of the absence or need for relief for those persons normally providing such care. Services can be offered in the home of an individual or in an approved facility such as a hospital, nursing home, foster home, or community residential facility. Case management is a system under which responsibility for locating, coordinating and monitoring a group of services rests with a defined person or institution. 5) The State may set limitations on the amount, duration and scope of services provided to individuals pursuant to the waiver which may vary from that made available

to other Medicaid recipients. The Conferees recognize that in order to provide an appropriate mix of services tailored to the individual, it might be inadvisable to set definitive limits on each service, since the written plan of care delineates the number and frequency of services, and the State may establish a per capita ceiling on the total cost of each client's care.

B. House bill.—The House bill provides that the Secretary may not approve such coverage unless the State provides assurances that implementation would not result in a level of expenditures for all long-term services greater than the level of expenditures without coverage for such noninstitutional services.

Senate amendment.—No provision.

Conference Agreement.—The conference agreement follows the House provision with a modification to specify that the total of all medical assistance for services provided to individuals who would qualify for community-based care under the State program may not exceed, on an average per capita basis, the total expenditures which would be incurred for such individuals if they were institutionalized. In determining the per capita costs the conferees expect the costs of medical assistance for these community-based care recipients will be divided by the number of individuals who are determined likely to be institutionalized without these services. The conferees believe this will provide protections to assure that aggregate costs will not be greater than they would have been without these alternative services.

C. House bill.—The House bill would permit the Secretary to approve coverage for room and board services.

Senate amendment.—The Senate amendment would not authorize coverage for such services.

Conference agreement.—The conference agreement does not include the House provision.

D. House bill.—No provision.

Senate amendment.—The Senate amendment authorizes the Secretary to grant a waiver only if State assures that necessary safeguard have been taken to protect the health and welfare of any recipients of such services.

Conference agreement.—The conference agreement follows the Senate amendment with an additional amendment requiring States to provide assurances that they will maintain appropriate financial records documenting the cost of services provided pursuant to the waiver; such records must be made available on request to the Secretary.

E. House bill.—The House bill provides that effective October 1, 1982, Federal matching payments would not be available for SNF or ICF services provided to individuals who had not received a comprehensive assessment of their need for long-term institutional care prior to admission to an SNF or ICF, except in urgent circumstances as provided by the Secretary.

Senate bill.—No provision.

Conference agreement.—The conference agreement does not include the House provision. However, the conferees note that if a State has an assessment system for persons needing long-term care, the costs of that system are eligible for Federal matching under the current Medicaid program.

F. House bill.—The House bill provides that a waiver granted a State under this provision shall be for three years, and may include a one-time waiver of Statewideness. Upon the request of the State, the waiver shall be extended for additional three-year periods unless the Secretary determines the assurances provided by the State have not been met.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provision.

The conferees note that the Department of Health and Human Services has supported demonstrations in 13 States, chiefly through waiver authority, to allow Medicare and Medicaid funds to pay for a variety of home and community-based services under different systems of organization and reimbursement. While these programs on the whole have States have received little encouragement to make permanent changes in long-term care provision, and many of these projects will terminate in the near future. The Conferees feel these projects will provide data useful to States requesting waivers under this section. Therefore, they direct the Secretary of HHS to review the progress of these demonstrations, and to consider continuing funding for those projects which are meeting their stated goals.

10. Encouraging HMO Participation in State Medicaid Plans

A. House bill.—The House bill maintains the current law requirement that States enter into prepaid risk arrangements only with federally qualified HMO's. It requires that States entering into agreements with HMO's do so under a contract containing financial accountability, nondiscrimination, and voluntary disenrollment provisions.

Senate amendment.—The Senate amendment repeals the current law provision that requires States that choose to enter into prepaid capitation or other risk-based arrangements to do so only with entities that meet Federal HMO standards (under title XIII of the Public Health Service Act), with certain exceptions. The Senate amendment permits a State to make payment on a prepaid capitation or other risk basis to any providers of services.

Conference agreement.—The conference agreement follows the House provision with an amendment to permit States to enter prepaid arrangements with other entities provided that such entity: (a) make covered services to Medicaid enrollees accessible on the same basis as to other Medicaid eligibles in the area; (b) has made adequate provision against risk of insolvency. Individuals eligible for benefits under a prepaid arrangement would in no case be held liable for debts of the organization in case of the organization's insolvency.

B. House bill.—The House bill modifies the current requirement that provided that within three years of entering into a Medicaid contract with a State an HMO must have an enrollment that consists of less than 50 percent Medicaid and Medicare beneficiaries. The House bill raises the current ceiling on Medicaid and Medicare beneficiaries in HMO's to 75 percent of enrollment and authorizes the Secretary to waive this ceiling altogether for public HMO's.

Senate amendment.—The Senate amendment repeals the current ceiling.

Conference agreement.—The conference agreement includes the House provision.

C. House bill.—The House bill authorizes the State to enter into arrangements with HMO's establishing minimum enrollment periods for Medicaid beneficiaries of not more than 6 months. Federal matching would be available for services provided to enrollees even if they lose their Medicaid eligibility during the minimum enrollment period.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision, but limits applicability to Federally qualified HMO's.

D. House bill.—The House bill authorizes the Secretary to waive any Federal Medicaid requirements necessary to enable a State to share with program eligibles, through direct payments or additional services, the saving resulting from the use of cost-effective methods of health care delivery, such as HMO's.

Senate amendment.—The Senate amendment modifies the House provision to preclude the sharing of savings through direct payments to program eligibles.

Conference agreement.—The conference agreement includes the Senate provision.

11. Eliminating Federal matching for excessive preoperative stays and unnecessary tests

A. House bill.—The House bill prohibits Federal matching payments for hospital services furnished to Medicaid eligibles admitted for elective surgical procedures (as defined by the Secretary) more than one day before the date of the operation.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

B. House bill.—The House bill prohibits Federal matching payments for inpatient hospital tests furnished to Medicaid eligibles not specifically ordered by the attending physician (except in emergency situations).

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

12. Permitting physician assistants and nurse practitioners to provide certain recertifications

House bill.—The House bill amends the current provision that requires a physician to recertify every 60 days the need for institutional services for Medicaid eligibles in a hospital, skilled nursing facility (SNF) or intermediate care facility (ICF). The House bill allows States to use physician assistants and nurse practitioners (within the scope of their practice under State law) to perform the recertification function.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

13. *Limitation on Requirement for Collection of Third-Party Payments*

House bill.—The House bill amends current law which requires States to recover payments due for services provided to a Medicaid eligible with private insurance or other third party coverage. The House bill provides that States need not collect third party liabilities in cases where the amount of reimbursement the State can reasonably be expected to recover is less than the costs of recovery.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

14. *Recovery of disputed claims*

House bill.—No provision.

Senate amendment.—The Senate amendment modifies current law provisions pertaining to recovery of amounts of Medicaid claims in dispute. The Senate amendment requires the Secretary to recover from a State any disputed claims after the issuance of a final notice of disallowance. If the State is successful on appeal, the Secretary would be required to return the disputed funds to the State, with interest (at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period). The Senate amendment applies to all disputed claims for which a notice of disallowance has been issued as well as for claims disallowed after enactment.

Conference agreement.—The conference agreement follows the Senate provision with a modification which permits the State to retain the funds in controversy except that the State would be liable for interest payments for the full time period it holds the funds if the disallowance is upheld on appeal. The conferees emphasize their intent that the Department should make every effort to expedite settling disputed claims as rapidly as possible.

15. *Services for the medically needy*

House bill.—No provision.

Senate amendment.—The Senate amendment modifies current law pertaining to conditions a State must meet if it chooses to offer coverage to its medically needy population. The Senate amendment repeals the following requirements: (a) a State must provide coverage to all medically needy groups; (b) services for all medically needy groups must be comparable in amount duration, and scope; (c) States must offer a minimum number of services to this population group; and (d) States must offer a mix of institutional and non-institutional care services (except that a State would continue to be required to offer home health services to any person eligible for skilled nursing facility care).

Conference agreement.—The conference agreement follows the Senate amendment with the following modifications (A) if a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (B) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (C) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer to all groups

covered in its medically needy program the same mix of institutional and noninstitutional services as required under current law.

The conferees understand the term "ambulatory services" to mean physician, clinic, nurse practitioner, dental, and preventive services. The conference committee expects the State to offer a service of sufficient amount, duration, and scope to achieve its purpose.

In the past the comparability language of the statute has been interpreted to mean identical treatment for eligibility criteria and scope of services within the medically needy program and between the categorically needy and medically needy programs. The intent of the amendment is to provide States' with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately. Nothing would allow, however, the State to cover individuals not covered under current law.

PREVENTIVE HEALTH SERVICES BLOCK GRANT ACT OF 1981 AND HEALTH SERVICES BLOCK GRANT ACT OF 1981

House bill.—In addition to reauthorizing categorical programs, the House bill consolidated certain health programs into two block grants. One block grant consolidated funding for preventive health services programs for control of rodents, and community and school-based fluoridation in the 314(d) authority of formula grants to the States for comprehensive public health services (health incentive grants).

Senate bill.—The Preventive Health Services Block Grant Act of 1981 (S. 1027) and the Health Services Block Grant Act of 1981 (S. 1028) consolidated a total of 17 formerly categorical health programs into two health block grants. These block grants would allocate to the states the same proportion of funds under the blocks as the state received in FY 1981 under the various separate categorical programs included in the block. After the first fiscal year in which a state received funds under both block grants, the legislature of the state would be required to conduct public hearings in order to be eligible to receive its allotment. The Chief Executive of a State would be required to prepare and furnish the Secretary of the Department of Health and Human Services a plan which would not be required to be elaborate, which describes how the state would carry out certain assurances and requirements contained in these acts. While the plans would have to be made available to public inspection within the state in a manner to facilitate comment, Federal approval of state plans would not be required.

CONFERENCE AGREEMENT

Health prevention and services block grant

The committee's bill consolidates into a Health Prevention and Services Block Grant the following categorical health programs:

Emergency Medical Services—Sec. 1202, 1203, 1203, PHS Act.

Health Incentive Grants—Sec. 314(d), PHS Act.

Hypertension Control—Sec. 317(j)(3), PHS Act.

Rodent Control—Sec. 317(a)(2) and 317(j)(2), PHS Act.

School-Based Fluoridation—317(j)(4), PHS Act.

Health Education/Risk Reduction—Sec. 401 and 420, P.L. 95-626.
Home Health—Sec. 339, PHS Act.

Rape Crisis Center—Sec. 602 Mental Health Systems Act.

The bill authorizes for this block grant \$95 million for fiscal year 1982, \$96.5 million for FY 1983 and \$98.5 million for fiscal year 1984.

The Conferees agreed to include a number of health programs in the Preventive Health and Health Services Block Grant. With the exception of the allotments for services for rape victims and the prevention of rape, each state's proportion of the new block grant allotments is equal to the percentage of funds received by the state or entities within the state in FY 1981 under the categorical programs that have been included in the block grant.

The conference substitute also provides for State continuation of present Emergency Medical Services grants for one year. While no minimum award is specified for these grants, the conferees do not intend that this provision be used as a "backdoor" or indirect method of defunding an existing grantee. Block grant funds used for emergency medical systems may not be used for purchasing equipment or to pay for the costs of operating such systems.

Special provision has been made to assure that states will continue the on-going efforts to combat hypertension by requiring that in FY 1982, each state must provide for hypertension programs at least 75% of the amount provided by the Federal government to that State or entities within the state in FY 81. In FY 1983, the required amount would be 70% of the FY 81 level, and in FY 1984, 60%.

In addition to the specific requirements for funding various activities indicated above, the conference agreement requires States to certify that they will establish (1) reasonable criteria to evaluate the effective performance of entities which receive funds under the block grant, and (2) procedures for substantive independent State review of failure to provide funds to entities which had previously received funds under this block grant or under the Federal categorical programs that have been included in the block grant.

As part of the application process, the State must also certify that it has identified those populations, areas and localities in the State with a need for preventive health and health services. It is the intent of the Conferees that the State provide a fair method for allocating its allotment in accordance with the needs of its population, areas and localities as determined under this assessment.

In addition, it is the intent of the Conferees that each State provide for an equitable geographic distribution of monies provided under the block grant.

Federal funds provided under the block would have to supplement and increase the level of State, local and other non-Federal funds that would have been expended in the absence of the block grant funds for such programs and activities and may not supplant such expenditure.

The application and certification process under this block grant has been greatly streamlined. The Secretary is prohibited from prescribing the manner of compliance with the certification process. This prohibition is intended to avoid complex pre-award review by the Secretary. The Conferees do not, however, intend that this pro-

hibition preclude the Secretary from carrying out his duties to ensure that the allotments are spent in conformity with the law.

The Conference agreement requires States to prepare annual reports on its activities under the block grant. These reports would be in such form and contain such information as the Secretary determines to be necessary (A) to determine whether funds were expended as required by the block grants and consistent with the needs of the State; (B) to secure a description of the activities of the State; and (C) to secure a record of the purposes for which funds were spent, of the recipients of funds and the progress made toward achieving the purposes for which the block grant was awarded to the States. However, in determining the information which must be included in this report, the Secretary may not establish reporting requirements that are burdensome.

States are also required to establish the fiscal control and fund accounting procedures necessary to assure the proper disbursement of an accounting for Federal funds received under the block grants and to prepare, at least once a year, an independent audit of funds received. In so far as practical, this audit should be done in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions. In addition, the Comptroller General is required to evaluate, from time to time, the expenditure by States of funds received, in order to assure that they are consistent with the provisions and requirements of the block grants.

The Conferees feel that these various features of the Preventive and Health Services Block Grant address the problems of inflexibility, lack of coordination, redundancy and burdensome regulation which characterized some parts of the categorical grant system, but at the same time address genuine concerns over State accountability without detracting from the State's authority to allocate block grant funds. The various requirements specified for the block grant are meant to be definitive and are intended to establish explicit boundaries for the Federal role in these programs.

The bill also provides for withholding power for the Secretary. The Conferees intend that this authority be used by the Secretary to ensure that all expenditure by States and entities receiving funds from States are directed to the intended beneficiaries of the services programs and in accordance with the requirements of the part and certifications provided by the State. The Secretary could do so, however, only after adequate notice and an opportunity for a hearing conducted within the State and after the Secretary has conducted an investigation. The Secretary could not withhold funds from a State for a minor failure to comply with the requirements and certifications of the block grant and would have to respond in an expeditious manner to complaints of a substantial or serious nature that the State has failed to comply.

In addition, the Secretary is required to conduct in several States in each fiscal year investigations of the use of funds received by the States under the Preventive and Health Services Block Grant. The Comptroller General is also authorized to conduct such investigations. States would be required to make appropriate books, documents, papers, and records available for such investigations and to permit any reasonable request for examination, copying, or me-

chanical reproduction, on or off the premises, of such papers and records. However, the Secretary or Comptroller General could not request any information not readily available to the State or entity and could not make an unreasonable request for information to be compiled, collected, or transmitted in any form not readily available.

Finally, the Conference agreement provides for criminal penalties for false statements made with regard to services or items funded with the block grant funds.

II. PROVISIONS RELATING TO SOCIAL SECURITY (OASDI)

1. *Elimination of the minimum benefit for all current and future beneficiaries*

House bill.—Eliminates the minimum benefit for all present and future beneficiaries. The amount payable to individuals already receiving benefits based on the minimum primary insurance amount would be recomputed based on their actual earnings record and according to recomputation procedures to be prescribed in regulations issued by the Secretary of Health and Human Services (HHS). All benefits payable to new beneficiaries would be based on their actual earnings, with no minimum payment level, effective for benefits payable after November 1981 for newly eligible beneficiaries, and for all others (current beneficiaries) beginning with benefits payable March 1982. In addition, persons aged 60 to 64 who are entitled to a minimum benefit before December 1981 would become eligible for a special SSI benefit if they qualify under all SSI rules except that pertaining to age. The amount of the special SSI payment would be limited to the difference between the minimum benefit the individual was receiving (without regard for the earnings test) and the recalculated benefit. These SSI payments would not be adjusted for increases in the cost of living; nor would these 60- to 64-year-old persons become eligible for certain other benefits including state supplementation, food stamps, medicaid, or social services as a result of this provision.

Senate amendment.—Same as House provision, except that the provision would be effective for all benefits payable beginning in August 1981.

Conference agreement.—The conference agreement provides for the House effective date with regard to new benefits (payable after November 1981); and all other beneficiaries would be affected in benefits for February 1982 (payable March 3) and thereafter. The Social Security Administration is directed to notify in writing on or before December 3, 1981 all current recipients of the minimum benefit. The notice shall read as follows:

This is to inform you that as a result of the elimination of the minimum benefit; your benefit may be reduced to some degree beginning with your March check. To determine the extent of the reduction, if any, and your possible eligibility for SSI and other assistance programs you may contact your local social security office.

2. *Restrictions on payment of lump-sum death benefits*

House bill.—The House provision would eliminate the lump-sum death payment effective for deaths occurring after August, 1981 in cases where there is neither an eligible spouse nor an entitled

child. Under the proposal, only surviving spouses who were living with deceased worker or are eligible to receive monthly cash survivor benefits upon the worker's death would receive the lump-sum death payment. If there were no eligible spouse, the lump-sum death payment would be payable to any child of the deceased worker who was eligible to receive monthly cash benefits as a surviving child. If there were no surviving spouse and the no children of the worker eligible for monthly benefits, then no one would be eligible to receive the lump-sum death payment.

Senate amendment.—The Senate amendment is identical to the House bill, except that it is effective with respect to deaths occurring after July 1981.

Conference agreement.—The Conference agreement adopts the restrictions on the payment of the lump-sum death benefit as passed by both the House and Senate. The provision is effective with respect to deaths occurring after August 1981.

3. Modification of month of initial entitlement for certain workers and their dependents.

House bill.—The House provision would provide that in the case of workers retiring at exact age 62 and in case of dependents (first claiming benefits at age 62) of retired workers, entitlements to benefits would begin with the first month throughout all of which the individual met all the requirements for eligibility. This change would not affect the disabled and their dependents who become entitled at the same time as the worker, although it would apply to dependents who came onto the benefit rolls at some time after the disabled worker becomes entitled. The provision would not affect entitlement to survivors' benefits, to reduced benefits for workers retiring after the month in which they attain age 62, to unreduced benefits in the month (and later months) that an otherwise entitled individual attains age 65, or to Medicare benefits. The provision is effective for months after August 1981.

Senate amendment.—No provision.

Conference agreement.—The conference agreement adopts the House provision.

4. Temporary extension of earnings limitations to include all persons under age 72

House bill.—The House provision would keep the exempt age under the earnings test at age 72 for 1982. Beginning in 1983, it would be lowered to age 70.

Senate amendment.—No provision.

Conference agreement.—The conference agreement adopts House provision.

5. Termination of mother's and father's benefits when youngest child attains age 16

House bill.—The House provision would end entitlement to benefits for the mother or father caring for a child or children receiving child's insurance benefits, when the youngest child reaches age 16 (rather than age 18, as under current law). The provision would not apply in the case of a parent caring for a disabled child aged 16 or over. The provision would be effective with respect to current beneficiaries only at the end of two years after the month of enactment,

but would be effective for parents becoming newly entitled in or after the second month after enactment. Benefits to the child or children in the family would not be affected. This provision is effective with respect to current beneficiaries two years after the month of enactment. It would be effective for parents becoming newly entitled in or after the second month after enactment.

Senate amendment.—No similar provision.

Conference agreements.—The conference agreement adopts the House provision.

6. *Modification of rounding rules*

House bill.—The House provision would provide for rounding benefit amounts down to the lower ten cents at each stage of computing benefits, except at the last step—the actual benefit amount payable per beneficiary. This would be rounded to the next lower dollar. For those beneficiaries electing supplementary medical insurance (SMI), the rounding would occur after the SMI premium was deducted from the OASDI benefit check. The provision applies to all beneficiaries, except for “transitionally” (Byrnes) and “uninsured” (Prouty) cases and applies to benefit amounts, including cost-of-living adjustments and benefit recomputations, for periods after August 1981.

Senate amendment.—The Senate amendment would provide that benefit amounts would be calculated to the nearest penny, with the final amount rounded to the next lower dollar. The provision applies to all beneficiaries, except for “transitionally” (Byrnes) and “uninsured” (Prouty) cases and applies to benefit amounts, including cost-of-living adjustments and benefit recomputations, for periods after June 1981.

Conference agreement.—The conference agreement adopts the House provision.

7. *Cost reimbursement for provisions of earnings information*

House bill.—The House provision would make clear that reimbursement of costs incurred by SSA in providing earnings information to employers seeking to comply with the Pension Reform Act of 1974 is not governed by the Freedom of Information Act or by the Privacy Act, which contain provisions limiting the extent to which the cost of furnishing information can be recovered, and would permit the Department to recover from the requesting party the full cost of retrieving and transmitting information for purposes of enabling pension plans to comply with the Pension Reform Act.

In addition, this provision would provide that the Department would have authority to recover the full cost of retrieving and transmitting any information requested for any other purpose not directly related to the administration of the program or programs under the Social Security Act. Changes made by this subsection are effective on date of enactment.

Senate amendment.—The Senate amendment is identical to the House-passed provision except that SSA is authorized to recover full costs only for information requests arising from requirements of the Pension Reform Act of 1974.

Conference agreement.—The conference agreement adopts the House provision.

8. Recency of work test for disability insurance

House bill.—No provision.

Senate amendment.—Would add an eligibility requirement for disability insurance benefits that an individual have 6 quarters of coverage during the 13 calendar quarters preceding the onset of disability in addition to the present law requirement of fully insured status and 20 quarters of coverage out of the last 40 quarters.

Conference agreement.—The Conference agreement adopts the House position with the understanding that this issue will be considered, along with the Administration's request for substituting a requirement of 30 quarters of coverage in the last 40 quarters the quarter requirement for 20 out of 40, in the social security financing bills pending before both Committees.

9. Modification of worker's compensation offset

House bill.—No provision.

Senate amendment.—Makes four modifications of the present worker's compensation offset. First, the offset provision would be expanded to include other disability benefits provided by Federal, State and local governments, except that needs-tested benefits, Veterans Administration disability benefits, and benefits based on public employment covered by social security would not be taken into account. Private insurance benefits also would not be taken into account. The amount of the reduction would be calculated as under the present worker's compensation offset provision. Second, the reduction in DI to take account of disability benefits provided under other Government programs would apply not only to workers under 62 and their families, but also to workers 62 through 64 and their families. Third, the reduction would be made beginning with the month during which the concurrent payments (Social Security disability and the other governmental disability payments) actually began. Fourth, the provision would amend existing law (which allows States to enact offsets so that Federal offset will not apply) February 18, 1981.

Conference agreement.—The conference adopts the Senate amendment with technical amendments by granting the waiver of the federal offset only in cases where the other public disability program began offsetting on or before ———.

The provision would be effective with respect to initial entitlements to disability benefits for individuals who become disabled after the sixth month preceding the month of ———.

10. Reimbursement of States for successful rehabilitation services

House bill.—Eliminates reimbursement from the OASI and DI trust funds to the state vocational rehabilitation agencies for rehabilitation services except in cases where the services have resulted in the beneficiary's performance of substantial gainful activity for a continuous period of 9 months. Such nine-month period could begin while the individual is under a vocational rehabilitation (VR) program and may also coincide with the trial work period and during the individual's waiting period for benefits. The services must be performed under a state plan for vocational rehabilitation services under title I of the Rehabilitation Act. In the case of any State which is unwilling to participate or which does have a plan which meets the requirements of the vocational Rehabilitation Act,

the Commissioner of Social Security may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The determination that the VR services contributed to the successful return of the individual to work and the determination of the costs to reimburse shall be made by the Commissioner of Social Security. Payments under this provision shall be made in advance or by way of reimbursement, with necessary adjustment for overpayments or under payments. The provision would be effective as to services rendered October 1, 1981 and subsequently.

Senate amendment.—Eliminate reimbursement from the trust funds in all cases.

Conference agreement.—The conference agreement adopts the House provision.

11. Elimination of benefits for post-secondary students.

House bill.—The House provision would eliminate new benefits for child beneficiaries 18 or older in post-secondary school and 19 or older in elementary or secondary school effective August 1982. However, students 18 or older who were entitled to a child's benefit in August 1981 and who began post-secondary school before May 1982 would be able to continue receiving benefits. The amount of their benefits, however, would not be adjusted for changes in the cost-of-living after August 1981. Further, beginning in August 1982, the amount of their benefits would be reduced each year by 25 percent of the August 1981 amount. Benefits would continue until the student turned 22, discontinued his education, or for some other reason ceased to qualify for benefits. In no case could benefits to post-secondary students 18 or older continue beyond July 1985. In addition, beginning in 1982, no benefits would be payable to these post-secondary students during the summer months, defined as the months of May through August.

Senate amendment.—The Senate amendment is identical to the House provision.

Conference agreement.—The conference agreement adopts the House and the Senate provision.

AID TO FAMILIES WITH DEPENDENT CHILDREN; CHILD SUPPORT ENFORCEMENT

Aid to Families with Dependent Children

1. Disregards from earned income for AFDC

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Current law provisions requiring States to disregard certain amounts of earned income for purposes of determining benefits in the AFDC program would be amended to standardize the work expense disregard at \$75 per month for full time employment, cap the child care disregard at \$160 per month, and change the order of the \$30 plus one-third disregard.

States would be required to disregard the following amount of earnings, in the following order:

(a) *Eligibility Determination*—the first \$75 of monthly earnings for full time employment (in lieu of itemized work expenses); and the cost of care for a child or incapacitated adult, up to \$160 per child per month.

(b) *Benefit Calculation*—the first \$75 of monthly earnings for full time employment; child care costs up to \$160 per child per month; and \$30 plus one-third of earnings not previously disregarded.

The \$30 plus one-third disregard would only be allowed during the first 4 consecutive months in which a recipient has earnings in excess of the standard work expense and child care disregards. After 4 months, the benefit would be determined without the \$30 plus one-third disregard for each month the family continues to receive AFDC and for 12 consecutive months after AFDC is terminated.

2. *Determination of income and resources for AFDC*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

In determining eligibility for AFDC, States would be required to limit allowable resources to \$1,000 (equity value) per family, excluding the home and one automobile. The value of the automobile would be limited by regulations.

In addition, States would be permitted to take into account the value of benefits received from food stamps or housing subsidies. This would be done by treating the value of the food stamp coupons or housing subsidy as income, up to the value for food or shelter that is included in the State payment standard.

3. *Income limit for AFDC eligibility*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Eligibility for AFDC would be limited to families with gross incomes at or below 150 percent of the State's standard of need.

4. *Treatment of income in excess of the standard of need; lump sum payments*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

For purposes of AFDC, income received in a month must be considered available as income in the month it is received and also in future months. Thus, if such income exceeded the standard of need in the months of receipt, the family would be ineligible in that month. In addition, any amount of the income that exceeds the initial month's needs standard would be divided by the monthly needs standard, and the family would be ineligible for aid for the number of months resulting from that calculation.

5. *Treatment of earned income advance amount under AFDC*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

In determining earned income for AFDC, the State must assume that an individual is receiving that earned income tax credit (EITC) advance payment that he or she is eligible to receive, regardless of

whether the person has applied for the advance payment (i.e., if the individual does not receive advance EITC payments, an amount equal to what he or she could get as advance payment is counted as earned income).

6. Income of stepparents living with dependent child

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

The income of a stepparent must be counted in determining eligibility and benefit amounts for AFDC applicants and recipients. (Countable income would include any amount which exceeds: (1) the first \$75 of earned income (a smaller amount may be prescribed for less than full-time work); (2) the amount specified in the State's standard of need as the amount required by the stepparent to support himself and his dependents living in the same household; (3) amounts paid by the stepparent to dependents living outside the household; and (4) payments of alimony or child support to individuals not in the same household. The law would be amended to preclude prorating of shelter allowances with regard to persons to whom this provision applies.

7. Community work experience programs

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be authorized to operate community work experience programs which serve a useful public purpose, and to require AFDC recipients to participate in these programs as a condition of eligibility. These programs would have to meet appropriate standards for health and safety, and could not result in displacement of persons currently employed, or the filling of established unfilled vacancies. Provision would have to be made for payment of reasonably necessary work expenses incurred by participants. Participants would not be required to work in excess of the number of hours which, when multiplied by the greater of the Federal or the applicable State minimum wage, equals the sum of the amount of aid payable to the family. Persons exempt from WIN registration would also generally be exempt from participation in this program, except that parents caring for a child under 6 (but not under 3) could also be required to participate if child care is available.

8. Providing jobs as alternative to AFDC

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be permitted to use savings from reduced AFDC grant levels to make jobs available on a voluntary basis. Under this approach, recipients would be given a choice between taking a job or depending upon a lower AFDC grant than now exists. States implementing this provision could do so in addition to or as an alternative to the community work experience approach.

States would use the savings from the reduced AFDC grant levels to provide or underwrite job opportunities for AFDC eligibles. For example, States could pay nonprofit and governmental entities a subsidy to cover part of the wage costs of hiring AFDC eligibles. (This type of subsidy would also be available to proprietary as well as nonprofit child day care providers but only if taken in lieu

of the tax credit which is otherwise available.) Acceptance of any job offered as a part of this program would be entirely voluntary on the part of the individual involved. At State option, medicaid coverage could be continued for participants in subsidized employment under this amendment.

States would have flexibility to implement the amendment for particular areas within the State or for particular categories of recipients and would also have the flexibility to modify the rules for treatment of income so as to avoid situations which would undermine the proposal. For example, modifications might be needed to adjust for offsetting increases in food stamp entitlement or to limit or eliminate the earned income disregard as it applies to those who choose to continue receiving AFDC. (States would not have authority under the proposal to enlarge the disregards otherwise allowable under Federal law.)

If a State elected to utilize this provision, its costs would be contained within the overall level of welfare costs as they would otherwise exist. The total amount of Federal funding for regular AFDC payments and for subsidies provided to employers under the voluntary jobs program could not exceed the present level of estimated AFDC spending in the State (after enactment of the other AFDC changes in the bill).

9. Work incentive demonstration program

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be authorized to operate a 3-year work incentive demonstration program as an alternative to the current WIN program. Not later than 60 days after enactment, the governor of a State wishing to conduct a demonstration would have to submit to the Secretary of HHS a letter of application expressing this intent. There would have to be an accompanying State program plan specifying (1) that the operating agency will be the State welfare agency, and (2) that required participation criteria will be the same (statewide) as are applied under the WIN program. However, the components of the program could be varied in different regions or political subdivisions of the State.

Participating States would be funded at a level equal to their 1981 WIN allocation augmented by any other Federal funding which may be available for establishing AFDC work programs in the State.

The purpose of the demonstration authority is to test the States' ability to develop alternatives to the current AFDC work requirements. Techniques to be used could include job training, job find clubs, grant diversion to either public or private employers, services contracts with State employment services, performance-based placement incentives, and others. A State's application would be deemed approved unless the Secretary notified the States within 45 days of application. An application could not be finally disapproved unless the Secretary determined that the State's program plan would be less effective than the WIN program.

10. Effect of participation in a strike on eligibility for AFDC

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

AFDC would not be payable to a family if a caretaker relative (mother or father) is, on the last day of the month, participating in a strike. If an individual in the family other than a caretaker relative is on strike, that individual's needs would not be included in determining the amount of the AFDC payment. In addition participation in a strike would not constitute good cause to leave or to refuse to seek or accept employment.

11. Age limit of dependent child

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Eligibility would be limited to a child under age 18, or, at State option, under 19, but only if the child is a full-time student in a secondary or technical school and may reasonably be expected to complete the program before he reaches age 19.

12. Limitation on AFDC to pregnant women

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be prohibited from paying to pregnant women with no other children until the 6th month of pregnancy. However, a State could provide medicaid for AFDC-eligible pregnant women with no children from the determination of pregnancy.

13. Aid to families with dependent children by reason of unemployment of a parent.

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Eligibility for AFDC on the basis of a parent's unemployment (AFDC-UP) would be limited to those families in which the principal earner is unemployed. The principal earner would be the parent who earned more income during the 2 years preceding the application for benefits. The entire family would be ineligible for AFDC if the principal earner is not registered for work or training.

14. Work requirements for AFDC recipients

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

AFDC work requirements would apply to children age 16 and over unless they are in elementary, secondary, or vocational school (not college). Parents caring for a child under 6 would be exempt from work requirements only if they are providing care with only brief or infrequent absences from the child.

15. Retrospective budgeting and monthly reporting

House bill.—States would be required to adopt a retrospective accounting and monthly reporting system. A family's eligibility for benefits would be determined on the basis of income and other factors in the current month, but the amount of benefits would be determined on the basis of income and other circumstances in the previous month. For the first month of eligibility, however, both eligibility and benefit amount would be determined on the basis of income and circumstances in the current month.

States would have to require all recipients to provide monthly reports on income, family composition, resources, and other relevant

factors. However, the Secretary of HHS could allow a State to require less frequent reporting for specified classes of recipients if the State demonstrates that the administrative cost of monthly reporting for these recipients is not worthwhile.

Senate amendment.—The Senate amendment is the same as the House bill, except that it does not allow waiver by the Secretary of the monthly reporting requirement.

Conference agreement.—The conference agreement follows the House bill.

16. Prohibition against payment of aid in amounts below ten dollars

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States could not make AFDC payments in amounts less than \$10 a month. Individuals denied a benefit as a result of this provision would be considered recipients for all other purposes, including medicaid eligibility.

17. Removal of limit on restricted payments in a State's AFDC program

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

The provision removes all restrictions on the number of cases in which vendor payments may be made by a State, and allows recipients to choose to have vendor payments made even though they could otherwise receive payments directly. There would not have to be a determination that the household cannot manage funds for those who elect to receive vendor payments.

18. Adjustment for incorrect payments

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be required to take prompt action to correct both overpayments and underpayments. Current recipients could either repay the amount of an overpayment or have the amount of their AFDC payment reduced. The AFDC payment for any month in which overpayments are being recovered, together with the recipient's liquid resources and all income, would have to equal at least 90 percent of the payment that a family would receive if it had no other income. Payments correcting underpayments could not be considered as income and could not be considered as resources in the month of receipt or the next month.

19. Reduced Federal matching of state and local AFDC training costs

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Federal matching for costs of training employees of State or local agencies administering AFDC would be reduced from 75 percent to 50 percent, effective with respect to expenditures made after September 30, 1981.

20. *Eligibility of aliens for AFDC*

House bill.—The House bill provides that, for the purposes of eligibility for AFDC, legally admitted aliens who apply for benefits for the first time after September 30, 1981 would be deemed to have the income and resources of their immigration sponsors available for their support for a period of 3 years after their entry into the United States. The eligibility of such aliens for AFDC would be contingent upon their obtaining the cooperation of their sponsors in providing necessary information to the State welfare agency to carry out this provision. The alien and the sponsor would be jointly and severally liable for repayment of any benefits incorrectly paid because of misinformation provided by the sponsor or because of his failure to report, and any such incorrect payments not paid would be withheld from any subsequent payments for which the alien or sponsor would otherwise be eligible under the Social Security Act.

A sponsor's income deemed to the alien would be considered unearned income and would result in a dollar-for-dollar reduction in the alien's AFDC benefit. The amount to be deemed would be equal to the total monthly amount of earned and unearned income of the sponsor and the sponsor's spouse reduced by an amount equal to the sum of (1) the lesser of 20 percent of earned income, or \$175; (2) the standard of need of the State for a family of the same size and composition as the sponsor and other individuals claimed by him as dependent (for Federal income tax purposes) who are living in the same household as the sponsor; (3) any amounts paid by the sponsor to individuals not living in the household who are claimed as dependents (for Federal income tax purposes); and (4) any payments of alimony or child support with respect to individuals not living in the household.

The amount of resources deemed to the alien would be equal to the amount of the resources of the sponsor and spouse as determined under the State's AFDC resource rules, reduced by \$1,500.

Under the provision, an alien applying for AFDC would be required to make available to the State agency any documentation concerning his income or resources or those of his sponsor (if he has one) which he provided in support of his immigration application. The Secretary of Health and Human Services would be authorized to obtain copies of any such documentation from other agencies (i.e., State Department or Immigration and Naturalization Service), and to provide the information, upon request, to a State agency. The Secretary of HHS would also be required to enter into cooperative arrangements with the State Department and the Justice Department to assure that the persons sponsoring the immigration of aliens are informed at the time of sponsorship that, if the alien applies for AFDC, the sponsorship affidavit will be made available to the public assistance agency and the sponsor may be required to provide further information concerning his income and assets in connection with the alien's application for assistance.

Under the provision, the income and resources of a sponsor which are deemed to an alien in a family would not be considered in determining the need of other, non-sponsored family members (e.g. a child born after entry into the U.S.) except to the extent such income or resources are actually available to them.

The provision would not apply to any alien who is (1) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act; (2) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act; (3) paroled into the United States as a refugee under section 212(d)(5) of such Act; (4) granted political asylum by the Attorney General under Section 208 of such Act; or (5) a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

21. *Effective date*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Except as otherwise specified, the effective date of all AFDC provisions is October 1, 1981, unless the State agency demonstrates that it cannot, by reason of State law, comply with the requirement. In such cases the Secretary of HHS may prescribe an effective date no later than the first month which begins after the close of the first session of the State's legislature ending on or after October 1, 1981.

Child Support Enforcement

1. *Collection of past-due child and spousal support from Federal tax refunds*

House bill.—The authority which is provided in current law for collection by the Internal Revenue Service of amounts which represent delinquent child support payments would be amplified in the following way. Upon receiving notice from a State child support agency that an individual owes past-due support which has been assigned to the State as a condition of AFDC eligibility, the Secretary of Treasury would be required to withhold from any tax refunds due that individual an amount equal to any past-due support. The withheld amount would be sent to the State agency, together with notice of the taxpayer's current address. The Secretary of Treasury would be required to issue regulations, approved by the Secretary of HHS, prescribing the timing and contents of notices by the States. States would be required to reimburse the Federal Government for the cost of the procedure. "Past-due support" is defined as the amount of a delinquency determined under court order or an order of an administrative process established under State law for support and maintenance of a child, or of a child and the parent with whom the child is living.

Senate amendment.—The Senate amendment is the same, except for technical differences.

Conference agreement.—The conference agreement follows the Senate amendment.

2. Collection of support for certain adults

House bill.—The authority which exists in present law to enforce obligations for support of a child is expanded to include, in addition, authority to enforce obligations for support of the parent with whom the child is living. Authority would also be added to use IRS collection procedures to collect support obligations with respect to the parent with whom the child is living and who is receiving AFDC. (Present law limits use of the IRS to collection of child support.) IRS collection procedures could also be used for the collection of obligations established by administrative process under State law. (Present law limits their use to obligations established by court order.)

Senate amendment.—The Senate amendment is the same as the House bill, except that, generally, spousal support may only be enforced in the case of parents who are receiving AFDC.

Conference agreement.—The conference agreement follows the House bill (except for technical differences).

3. Cost of collection and other services for non-AFDC families

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

States would be required to retain a fee equal to 10 percent of the support collected on behalf of a non-AFDC family. This 10 percent fee would be charged against the absent parent and added to the amount of the collection.

4. Child support obligations not discharged by bankruptcy

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

A provision of the Social Security Act, previously in effect, would be reinstated, declaring that a child support obligation assigned to a State as a condition of AFDC eligibility is not discharged in bankruptcy. The provision would be effective upon enactment.

5. Child support intercept of unemployment benefits

House bill.—The House bill would require child support enforcement agencies to determine on a periodic basis whether any individuals who owe child support obligations enforceable by the agency are receiving unemployment compensation or trade adjustment assistance benefits (under chapter 2 of the Trade Act of 1974). The child support enforcement agency would be required to collect any outstanding child support obligations owed by an individual receiving unemployment benefits—through an agreement with the individual or, in the absence thereof, the legal processes of the State—by having a portion of the individual's employment benefits withheld and forwarded to the State child support agency. As a condition for receipt of Federal administrative grants under title III of the Social Security Act, agencies charged with the administration of the State unemployment compensation laws would be required to withhold and forward to the child support agency the amount of the individual's unemployment benefits specified in the agreement or otherwise required to be withheld as a result of legal process. An agreement to withhold less than the full amount owed would not excuse the individual's legal obligation. Amounts withheld would be forwarded to the child support agency. The provision

has an effective date of Oct. 1, 1981, except that State plan requirements would not have to be met before Oct. 1, 1982.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

6. *Effective date*

Both the House bill and the Senate amendment included the following identical provision which was agreed to by the conferees:

Except as otherwise specified, the effective date of all child support enforcement provisions is October 1, 1981, unless the State agency demonstrates that it cannot, by reason of State law, comply with the requirement. In such cases the Secretary of HHS may prescribe an effective date no later than the first month which begins after the close of the first session of the State's legislature ending on or after October 1, 1981.

SUPPLEMENTAL SECURITY INCOME BENEFITS

1. *Retrospective accounting*

House bill.—The House bill provides generally for changing the present quarterly prospective method of accounting for SSI to a monthly retrospective system. The bill requires that the SSI *benefit amount*, in general, be determined on the basis of the prior month's income and circumstances, i.e. retrospectively. *Eligibility* would be determined on the basis of income and other circumstances of the current month, i.e. prospectively. However, both eligibility and benefit amount would be determined on a current (prospective) basis (1) for the month in which an application is filed, or (2) for any month in which a significant change occurs (as determined by the Secretary) in the recipient's living arrangements.

The bill also provides authority for the Secretary to waive the requirement that the SSI benefit standard be reduced to \$25 in the case of individuals in certain medical institutions in order to promote the individual's removal from the institution. In addition, the Secretary would be allowed to make transitional payments for the period immediately following the effective date of the amendment. The amendment is effective with respect to months after the first calendar quarter which ends more than five months after the month of enactment.

Senate amendment.—The Senate amendment is the same as the House bill, except that it does not give the Secretary authority to determine eligibility and benefits on a current basis in the case of recipients who experience a significant change in living arrangements, and includes minor differences in the provisions giving the Secretary authority to grant waivers and to make transitional payments.

Conference agreement.—The conference agreement follows the Senate amendment.

2. *Eligibility of SSI recipients for food stamps*

House bill.—The House bill modifies current Federal SSI food stamp "cash-out" requirements so that a State could continue to "cash-out" food stamps for SSI recipients so long as it (1) had previ-

ously increased its supplementary benefits to include the bonus value of food stamps, (2) was providing a cash payment in lieu of food stamps as of December 1980, and (3) continued to pass-through the Federal cost-of-living increases as required under section 1618 of current SSI law.

The provision affects SSI recipients in Massachusetts, Wisconsin and California. The effective date is July 1, 1981. (A bill providing this authority on a temporary basis, to Aug. 1, 1981, was signed into law on June 30 as Public Law 97-118.)

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

3. Payment to States with respect to certain unnegotiated checks

House bill.—The House bill would limit the negotiability of SSI checks to 180 days from date of issuance. The amount from such unnegotiated checks which represent a State supplementation payment would be returned or credited to the State. The bill would require the Social Security Administration, to the maximum extent feasible, to determine the whereabouts and eligibility of those individuals whose benefit checks were not negotiated within the 180 day limit.

Senate amendment.—No provision.

Conference agreement.—Under the conference agreement, the negotiability of SSI checks would continue to be unlimited. However, the Secretary of the Treasury would be required, on a monthly basis, to notify the Secretary of HHS of all benefit checks which have not been presented for payment within 180 days after the date of issuance. As provided in the House bill, the Secretary of HHS would be required to return (or credit) amounts which represent State supplementary payments to the State. In addition, the Social Security Administration would be required to attempt to determine the whereabouts and eligibility of those recipients whose checks were not negotiated within 180 days of issuance. The provision is effective October 1, 1981.

4. Funding of rehabilitation services for SSI recipients

House bill.—No provision.

Senate amendment.—The Senate amendment would repeal the authority under SSI for the Secretary to reimburse State vocational rehabilitation agencies for services provided to blind and disabled recipients of the SSI program.

Conference agreement.—The conferees agreed to allow the Secretary to reimburse State vocational rehabilitation agencies only for services provided to SSI recipients who subsequently perform substantial gainful activity which lasts for a continuous period of 9 months, under the same conditions as are applicable with respect to reimbursement for services to social security beneficiaries (as provided in this Act). The provision is effective October 1, 1981.

5. Special interim cost-of-living increase in SSI benefits

House bill.—The House bill provides that any temporary cost-of-living increase in title II (OASDI) benefits made in 1982 by the Reconciliation Act would result in the same percentage increase in benefits under title XVI (SSI). (This provision is contingent on a

Committee-approved provision to change title II cost-of-living increases which was deleted by the Latta floor amendment. Without the title II amendment it is inoperative.)

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the Senate amendment.

SOCIAL SERVICES BLOCK GRANT

House bill.—Effective October 1, 1981, the House bill would repeal the following programs and consolidate activities and funding in a new freestanding social services block grant: title XX social services and training; Child Abuse Prevention and Treatment and Adoption Reform Acts; Runaway and Homeless Youth Act; and titles I, II, III, IV, VI, VII, and IX of the Community Services Act. The bill would make no change from present law in the title IV-B child welfare services and title IV-E foster care and adoption assistance programs.

The bill would authorize (subject to appropriations) \$3.123 billion for the new block grant in fiscal year 1982 and each of the three succeeding fiscal years. This amount represents a 16 percent decrease from the CBO 1982 baseline estimate for the consolidated programs. Funds would be allotted to States on the basis of State allotments or obligations in 1981 under programs repealed by the Act, and under foster care maintenance payments authorized by title IV of the Social Security Act, and the special social services provisions for Puerto Rico, Guam and the Virgin Islands under section 1108(a) of the Social Security Act. There would be no State matching requirement under the block grant program. States would be allowed to transfer up to 10 percent of their social services block grant allotment for use under block grants for health services, health promotion and disease prevention, and energy assistance. (In 1982 and 1983 each State could transfer only an amount equal to its share of \$255 million to the energy assistance block grant.) Funds could be used to provide foster care maintenance payments and adoption assistance without limitation as to the amount.

The current, separate title XX training program would be repealed. Funds provided under the new block grant could be used to pay all training costs, including training provided through tax-exempt nonprofit organizations, or by individuals with social services expertise. Restrictions on use of funds would be similar to those in present law, including restrictions which generally prohibit funding of medical or remedial care; the purchase, construction, or major modification of land, buildings, or equipment; educational services which are generally available; and others.

Services would be authorized to be provided to individuals and families, particularly those most in need, but would not have to be targeted toward any particular group.

Before States could use their allotment in any fiscal year, they would be required to report on their intended use of funds. The report would describe services to be provided and the populations to be served and would be available to the general public for review and comment. States could revise the plan throughout the year.

States would be required to prepare reports at least every 2 years, in order to provide a description of activities, to secure a record of purposes for which funds were spent, and to determine the extent to which funds were spent consistently with the States' annual report on planned activities. States would also be required to audit their expenditures at least every 2 years. Audits would be submitted to the State legislature and the Secretary. States would either repay amounts found not to have been spent in accordance with the Act, or the Secretary could offset these amounts against future payments.

The Secretary of HHS would be authorized, either directly or through grants and contracts, to provide training related to the purposes of the Act, and to conduct ongoing activities of national or regional significance similar to those authorized under present law.

Senate amendment.—Effective October 1, 1981, the Senate amendment would repeal the following programs and consolidate activities and funding in a new social services block grant, authorized under title XX of the Social Security Act: title XX social services and training; title IV-B child welfare services; and title IV-E foster care and adoption assistance.

The Senate amendment would premanently authorize (on an entitlement basis) \$2.639 billion annually for the new social services block grant. This amount represents a 25 percent decrease from fiscal year 1981 budget authority for the consolidated programs.

States would be required to implement foster care, adoption assistance and child welfare services programs in accord with requirements of present law. These include provisions for individual case plans, case review systems, services programs designed to assist children in returning to their homes, and per-placement preventive services. If a State failed to meet the requirements, its title XX block grant funding would be reduced. The reduction would be equal to the same proportion of its block grant allocation for the year in question as the funds it received in 1981 for AFDC foster care, adoption assistance and child welfare services were of the combined amount of funds it received for those programs and title XX social services.

Specifically, the requirements that would have to be met are: (1) Beginning October 1, 1982, States would have to have in effect a foster care and adoption assistance program that meets the specifications of the current title IV-E program. (2) In addition, beginning in 1985, States would have to meet all the foster care protection requirements (including pre-placement preventive services) that would be required under the present IV-B child welfare services law if the full \$266 million authorized for the program were actually appropriated.

States would be required to spend for foster care, adoption assistance and child welfare services at least 75 percent of the amount they spent for these programs in 1981. And, foster care maintenance payments could not represent a greater proportion of a State's total title XX block grant expenditures than such payments in 1981 represented of the State's total allotment under the foster care, child welfare services, adoption assistance and social services programs.

State allotments would be based on State allotments or obligations in 1981 under the existing title XX, title IV-B, title IV-E,

title IV-A and section 1108 (a) of the Social Security Act. There would be no State matching requirement for the new block grant program.

As under the House bill, the current, separate title XX training program would be repealed, and authority would be provided for funding training under the new block grant. Unlike the House bill, the Senate amendment would not authorize training provided by tax-exempt nonprofit organizations or individuals with social services expertise. Like the House bill, the Senate amendment would allow inter-block transfer of funds.

The Senate amendment generally would prohibit funding for the same kinds of activities as the House bill (which are similar to present law). It would require that day care provided with block grant funds meet applicable State and local standards. It would also authorize States to make grants to qualified day care providers to pay wages of welfare recipients hired as day care workers, as provided in current law.

Requirements for reports and audits would be similar to those in the House bill, except that reports would also have to include information relating to the State's programs for foster care and adoption assistance, and would have to be transmitted to the Secretary.

Conference agreement.—The conference agreement provides for amending the existing title XX of the Social Security Act to establish a new block grant to States for social services. Under the conference agreement, which generally follows the Senate amendment, the new block grant would not incorporate the child welfare services, foster care, and adoption assistance programs.

The new title XX would provide that each State be entitled to an annual allotment for operating social services programs aimed at meeting the following goals:

- (1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- (2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- (3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitation, or reuniting families;
- (4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- (5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

The amount of the allotment for each State would be its share of a national total of \$2.4 billion in 1982, \$2.45 billion in 1983, \$2.5 billion in 1984, \$2.6 billion in 1985, and \$2.7 billion in 1986 and years thereafter. Allotments would be based on State population. (The share allotment for Puerto Rico, Guam and the Virgin Islands and the other Mariana Islands would be based on their share of the amounts allotted to them in 1981 under title XX, reduced to reflect the new funding levels.)

As under the Senate amendment, the program would operate as an appropriated entitlement in which the Federal Government is obligated to appropriate an amount sufficient to meet all qualified State expenditures up to the amount of the State allotment. As

under both the House bill and the Senate amendment, there would be no non-Federal matching requirement, and States would be able to claim funds within their allotments for expenditures in the fiscal year to which the allotment applies or in the following year. Unexpended funds would not be reallocated. However, each State would be authorized to transfer up to 10 percent of its annual title XX allotment for expenditures under health, or energy assistance block grant programs.

Expenditures for services could include expenditures for administration (including planning and evaluation); personnel training and retraining directly related to provision of those services (including both short- and long-term training at educational institutions through grants to institutions or by direct financial assistance to students); and conferences or workshops, and training or retraining through grants to nonprofit organizations or to individuals with social services expertise.

As under both the House bill and the Senate amendment, before expending funds under the new title XX program for any fiscal year, States would be required to develop and make public a report on how the funds are to be used, including information about the types of activities to be funded and the characteristics of the individuals who will be serviced. This report would be revised throughout the year, as necessary. As under the Senate amendment, the report would have to be submitted to the Secretary.

As under both the House bill and the Senate amendment, each State would determine the types of services to be provided, and, unlike present law, there would be no requirement that a specific portion of the funds be used for welfare recipients, or that services be limited to families with incomes below 115 percent of State median income.

Title XX funds could not be used for the following specified purposes:

- (1) the purchase or improvement of land or buildings;
- (2) room and board cost (except for certain short-term or emergency shelter);
- (3) wage payments other than payments under the provisions for subsidizing the costs of hiring welfare recipients in child care jobs;
- (4) medical care (except where it is an integral part of another service) other than initial detoxification of an alcoholic or drug dependent individual, family planning services, or rehabilitation services;
- (5) institutional services provided by the institution (except for rehabilitation services or services for alcoholic or drug dependent individuals);
- (6) educational services which are generally available; and
- (7) services in the form of cash payments.

As in both the House bill and the Senate amendment, the Secretary of HHS would have authority to waive the prohibition against medical services and against the purchase or improvement of land or buildings where he finds extraordinary circumstances justify such uses.

As under the Senate amendment, child care provided with title XX funds would have to meet applicable State and local laws. The conference agreement follows the Senate amendment in continuing the provisions in present law which authorize use of social services

funds to make grants to qualified day care providers to pay wages (with specified restrictions) of welfare recipients hired as day care workers.

As under the House bill and the Senate amendment, States would be required at least every 2 years to prepare and make available reports showing in detail how the program funds were expended and demonstrating that such expenditures meet the requirements of title XX. The report would also have to be transmitted to the Secretary, as required in the Senate amendment. In addition, States would be required to audit their programs at least every 2 years (with the audit being conducted by an entity which does not receive title XX funds). Any amounts expended which did not comply with title XX requirements would be recovered by the Federal Government.

As under the Senate amendment, the Department of Health and Human Services would be required to conduct a study to identify ways States could evaluate their programs. The study would consider Federal incentive payments as an option, and would be submitted to Congress within a year of enactment.

TITLE XXIV

PROVISIONS RELATING TO UNEMPLOYMENT COMPENSATION

1. elimination of national trigger under the extended benefits program

Present law.—Under current law, up to 13 additional weeks of extended unemployment compensation, beyond the usual maximum of 26 weeks of State benefits, are payable to unemployed individuals who exhaust their State benefits during periods of high unemployment. Extended benefits are paid in all States, regardless of State unemployment rates, when the national insured unemployment rate (IUR—the percentage of workers covered by the State unemployment compensation program who are currently claiming State or extended benefits) reaches 4.5 percent. Fifty percent of the costs of extended benefits are paid from proceeds of the Federal unemployment tax and fifty percent are paid from State unemployment taxes.

House bill.—Repeals the national trigger, effective for weeks beginning after the date of enactment.

Senate amendment.—Same as House bill, except effective July 1, 1981.

Conference agreement.—The conference agreement adopts the House provision.

2. modification of optional state trigger level for extended benefits

Present law.—Under current law, extended benefits are payable in any State in which the insured unemployment rate (IUR) is at least 4 percent and, in addition, is 20 percent higher than the average of the same period in the previous years. When the “20 percent factor” is not met, a State, at its option may provide extended benefits when the State IUR reaches 5 percent, regardless of the IUR in previous years.

House bill.—No similar provision.

Senate amendment.—The Senate provision raises from 4 percent (plus 20 percent factor) to 5 percent (plus 20 percent factor) the IUR at which extended benefits would be payable in any State, and also raises the optional trigger rate from 5 percent to 6 percent. The provision is effective for weeks beginning after September 25, 1982.

Conference agreement.—The conference agreement adopts the Senate amendment.

3. exclude extended benefits claimants in determining rate of insured unemployment for extended benefit trigger calculation

Present law.—Under current law, the insured unemployment rate (IUR)—used to determine unemployment levels for the purpose of triggering “on” extended unemployment compensation benefits—is calculated by dividing the average weekly number of individuals filing claims for regular State unemployment benefits or Federal/State extended benefits by the average monthly covered employment for the first four of the most recent six calendar quarters.

House bill.—The House provision excludes extended benefit claimants from the calculation of the IUR for extended benefits trigger purposes. Only individuals filing claims for regular State unemployment compensation would be included in calculating extended benefits trigger rates. The provision is effective July 1, 1981.

Senate amendment.—Same as House bill, except effective on date of enactment.

Conference agreement.—The conference agreement adopts the Senate amendment.

4. require 20 weeks of work or equivalent wages for extended benefits

Present law.—Under present law, all States require an individual to have worked for a certain length of time or to have earned a specified amount of wages in the base year to be eligible for State unemployment compensation benefits. There are no additional work or wage requirements for receipt of extended benefits. A person who exhausts State benefits during a period when extended benefits are payable, and who continues to meet all State and Federal requirements, is eligible to receive extended benefits for one-half of the number of weeks (up to a maximum of 13 weeks) he or she received State benefits.

House bill.—No similar provision.

Senate amendment.—The Senate provision requires extended benefits claimants to have worked at least 20 weeks, or have an equivalent amount of wages, during the base period in order to receive extended benefits. A State could use one of the following measures of equivalent wages:

Wages equal to 40 times the claimant’s weekly benefit amount; or

Wages equal to 1.50 times the claimant’s wages earned in the quarter with the highest wages.

The provision is effective for weeks beginning after September 25, 1982.

Conference agreement. The conference agreement adopts the Senate amendment.

5. *limitations on unemployment benefits paid to ex-servicemen*

Present law.—Under current law, Federally funded unemployment benefits are provided to former military personnel upon their separation from military service if they meet the eligibility requirements of the State in which they apply for unemployment compensation. The military service of an individual qualifies as wages or employment in the determination of eligibility for unemployment benefits only if the person has (1) served 365 or more continuous days of active duty (unless separated after a shorter period because of a service-incurred injury or disability) and (2) was separated under other than dishonorable conditions. Leaving the military at the end of a term of enlistment, even if the person was eligible to reenlist, is not considered a “voluntary quit” under state law in the determination of eligibility for unemployment benefits.

House bill.—The House provision (1) increases from 365 to 730 days the length of continuous military service a person must have in order for such service to qualify as employment for unemployment compensation purposes; (2) requires a four-week waiting period between the week in which an individual is separated from the military and the week in which he or she first becomes entitled to compensation; and (3) limits an eligible ex-servicemember’s total entitlement (including extended benefits) to no more than 13 times the weekly benefit amount payable. The provision would be effective with regard to new claims filed on or after October 1, 1981.

Senate amendment.—The Senate provision disqualifies for unemployment compensation those ex-servicemembers who leave the military at the end of a term of enlistment and are eligible to reenlist, effective July 1, 1981.

Conference agreement.—The conference agreement adopts the Senate amendment with modification in the effective date so that provision applies to individuals who leave the military on or after July 1981, but only to weeks of unemployment compensation payable after date of enactment.

7. *Certification of State unemployment laws*

Present law: Under current law, a payroll tax of 3.4 percent on the first \$6,000 of wages paid to employees is levied on employers (Federal Unemployment Tax Act, FUTA). If a State’s unemployment compensation program is certified by the Secretary of Labor as meeting certain requirements of Federal law, employers in that State receive a 2.7 percent credit against the 3.4 percent FUTA tax.

House bill: No similar provision.

Senate amendment: The Senate amendment (1) prohibits certification by the Secretary of Labor of any State which has failed to amend its unemployment compensation law so that it contains provisions required to be included by this bill, including provisions of the Federal-State Extended Unemployment Compensation Act; (2) delays for 1 year the effective dates of Senate amendment sections 741 and 742 for any State whose legislature does not meet at least 25 calendar days after the date of enactment and before September 25, 1981; (3) delays for 1 year the effective dates of Senate amendment sections 743 and 744 for any State whose legislature does not meet at least 25 calendar days after the date of enactment and before September 25, 1982.

Conference Agreement: The Conference agreement adopts the Senate amendment.

6. *Federal unemployment compensation loans to States (sec. 746 of the Senate amendment)*

Present law: Under present law, the costs of regular State benefits and one-half of the costs of extended benefits are funded by State unemployment payroll taxes. If State unemployment tax revenues exceed benefit costs, the surplus amounts are retained by the State in an interest bearing account in the Federal Unemployment Trust Fund. If the benefit costs exceed revenues, States draw down their accumulated surpluses from prior years. If those surpluses become depleted, States are allowed to receive interest-free Federal advances from an account which is funded through the Federal unemployment payroll tax (FUTA). If there are insufficient Federal unemployment tax revenues for this purpose, additional funds are obtained as interest-free advances from the general fund of the Treasury.

The standard *net* Federal unemployment tax, which is paid by employers in all States, is currently 0.7 percent on the first \$6,000 paid annually to each employee. The *gross* FUTA tax rate is 3.4 percent; however, employers are eligible for a 2.7 percent credit against this Federal tax (unless, as explained below, the State is subject to a reduction in this credit because of outstanding Federal advances). The 2.7 percent credit reduces the *gross* tax rate from 3.4 to the *net* tax rate of 0.7 percent.

States with an outstanding advance from the Federal Government must repay it fully within two to three years. (Technically, it must be repaid by November 10 of the calendar year in which the second consecutive January 1 passes with the State still having an outstanding advance. This means that a State may have from 22 months and 10 days to 34 months and 10 days to repay the advance, depending on when it obtained the outstanding advance.)

If a State does not fully repay an advance within the 22 to 34 month period, employers in the State become subject to a reduction in the 2.7 percent credit against the 3.4 percent Federal tax. This credit reduction is applied to the calendar year beginning with the second consecutive January 1 in which the advance has been outstanding and continues until the advance is repaid fully. The increased tax resulting from the credit reduction is payable no later than January 31 of the next calendar year. The proceeds from the increased tax are used to reduce the principal of the State's outstanding loan.

House bill: No similar provision.

The Senate bill would cap the credit reduction under certain conditions and would charge interest on advances under certain conditions:

I. Cap on Credit Reduction.

A. *Limit on Credit Reduction.* Employers in States otherwise subject to a credit reduction and meeting certain solvency requirements would be eligible for a cap on the credit reduction equal to the higher of: (1) the credit reduction in effect during the previous year; or (2) 0.6 percent. An additional 0.3 percent would be added to the cap on the credit reduction, allowing the credit reduction to in-

crease to 0.9 percent, if a State has an insured unemployment rate for the taxable year that does not exceed 80 percent of the average insured unemployment rate for the last two years.

B. Solvency Requirements. On November 10 of the tax year of the solvency requirements are met if the Secretary of Labor determines that: (1) the State's outstanding advances on the immediately preceding September 30 are not greater than on the second preceding September 30; (2) the State did not lower its unemployment tax effort in the fiscal year ending on the immediately preceding September 30; and (3) the State did not take action that caused a net decrease in the solvency of its unemployment compensation program.

C. Consecutive January Firsts Ending before October 1, 1984. If a State qualifies for the cap in any year, but fails to qualify for the cap in later years, the "capped" years will not be counted in determining the level of credit reduction for those later years. This rule applies only to years prior to 1984.

D. Waiver of Solvency Requirement B. (1) During Periods of Recession. The solvency requirement dealing with net, new borrowing may be waived at State option if a State meets the following conditions in the fiscal year ending with the immediately preceding September 30: (1) the State average total unemployment rate for the preceding 3 taxable years is at least 110 percent of the national average, and (2) the State average employer tax rate on total wages was at least 150 percent of the national average employer tax rate on total wages for such fiscal year. No State may use this waiver for more than two consecutive years.

E. Repayment Requirements. Any State that used the waiver on the net new borrowing provision (B) (1) must repay the additional advances received under this waiver within 24 months of the beginning of the fiscal year in which it did not meet the waiver requirements. Any State that does not repay the new advances under these conditions will be ineligible for the cap on the credit reduction for the tax year in which the 24-month period ends and will be ineligible until the tax year starting in the Federal fiscal year in which the repayment of this new borrowing has been made.

Effective dates: Applies to taxable years 1981 through 1983.

II. Interest on Advances. Any advance made to a State unemployment program after May 5, 1981, and before October 1, 1984, would be charged a 10 percent interest rate to be compounded quarterly. Such interest would be waived, however, if: (1) the State repays the advance fully within the Federal fiscal year in which it was made; and (2) the Secretary of Labor certifies by September 1 of the fiscal year in which the advance was made that the State unemployment account has sufficient reserves and income to pay 6 months worth of benefits after the beginning of the next fiscal year. The State may not pay the interest charged directly or indirectly from its State unemployment account. If it does, the Secretary of Labor would not certify the State unemployment compensation law, meaning that employers in that State would be subject to the full Federal payroll tax. Interest on an advance made and not repaid within a fiscal year would be due by the end of that year. Interest on prior borrowing would be required to be paid before the last day of the quarter in which it is due.

Any repayments by the State (including repayments resulting from a credit reduction) would be first applied to reducing the oldest loan balance. (An exception to this rule would apply in the case of trust fund payments which entirely repay borrowing within the fiscal year so as to meet the interest waiver requirement. Interest on advances before October 1, 1981, would be due after October 1, 1981, on a date that the Secretary of Treasury deems appropriate.

Effective May 6, 1981, through September 30, 1984.

Conference Agreement: The conferees agreed to the following.

1. Limit on Federal Tax Credit Reduction

Effective October 1, 1981, through December 31, 1987, in States that meet the solvency requirements described below, reductions in the Federal tax credit resulting from outstanding Federal loans would be limited to 0.6 percent or, if higher, the level that was in effect in the year prior to the year the State qualifies for the limitation. The years in which a State meets the requirements, and therefore qualifies for a limitation in the credit reduction, would not count in determining the level of the increase in the *net* Federal tax in subsequent years in which the State does not meet the solvency requirements.

In order to qualify for the limitation on the credit reduction for tax years 1981 and 1982, a State would have to meet the conditions of (A) and (B) described below. In subsequent years a State must meet the conditions of (A), (B), (C) and (D) described below.

(A) no State action was taken during the 12-month period ending on September 30 of the such taxable year in question (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has resulted or will result in a reduction in such State's unemployment tax effort (as defined by the Secretary of Labor in regulations);

(B) no State action was taken during the 12-month period ending on September 30 of the taxable year (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has resulted or will result in a net decrease in the solvency of the State unemployment compensation system (as defined by the Secretary of Labor in regulations);

(C) the estimated average unemployment tax rate in the State for the year in question (total unemployment taxes paid by State employers in the calendar year divided by total wages of employers subject to State unemployment taxes) is equal to or greater than the average of the ratio of benefit expenditures (minus reimbursable benefits) to total wages of employers subject to State unemployment taxes for the last 5 calendar years. (For purposes of this requirement, for tax years 1981-1983, all Federal unemployment taxes in excess of the standard amount (currently 0.7 percent)—using the Federal tax rate the State would pay if it qualifies for the limit on the tax credit reduction—would be added to all State unemployment taxes in determining the average tax rate in the State. For tax year 1984, only the amount of Federal unemployment taxes in excess of the standard 0.7 percent plus 0.6 percent would be added to State unemployment taxes. Beginning with tax year 1985, only State taxes would be counted. For tax years 1981-1983, in making the determination of benefit expenditures for the

previous 5 years, only expenditures for regular State benefits would be counted for all years up through 1981. For tax year 1984, the State share of extended benefits payments would be added to State benefit expenditures for 1981; and, for tax year 1985, extended benefit payments would be added to State benefit expenditures for 1980 and 1981. For all years beginning with 1982, benefit expenditures would include payments for regular State benefits, extended benefits and interest charges on Federal loans); and

(D) the amount of the State's outstanding loans on September 30 of the tax year in question was not greater than the amount of outstanding loans for the State on September 30 of the third preceding taxable year (or, for purposes of applying this subparagraph to the taxable year 1983, September 30, 1981).

This means that, for tax year 1983, the State's loan balance as of September 30, 1983 will be compared to, and must not be greater than, the State's loan balance as of September 30, 1981. For tax year 1984, the loan balance as of September 30, 1984, must not be higher than the balance on September 30, 1981. For tax year 1985, the loan balance on September 30, 1985, must not be higher than the balance on September 30, 1982. For tax year 1986, the loan balance on September 30, 1986, must not be higher than the balance on September 30, 1983. And, for tax year 1987, the loan balance on September 30, 1987, must not be higher than the balance on September 30, 1984.

The conferees are concerned that the provisions of the conference agreement be approached by the States with a good faith effort to restore solvency and not be manipulated as a means of evading the difficult measures that must be taken to put the unemployment program on a sound footing. Consideration must be given to the need for benefit constraint and not simply for tax increases. It would be clearly inconsistent with the intent of the agreement if States were to use the need for increased taxes to meet the benefit cost ratio test as an occasion for unjustified benefit increases or if they were to meet the requirement of not increasing their loan balance by continually reborrowing the reductions in loan balance which result from the reduced Federal tax credits.

2. Interest on Federal Unemployment Compensation Loans to States

Interest would be charged on unemployment loans to States received between April 1, 1982 and December 31, 1987. The rate of interest charged in any year would be the same rate as that paid by the Federal government on balances in State unemployment trust funds for the quarter ending December 31 of the preceding year, but no higher than 10 percent per annum.

A State would *not* have to pay interest on a loan that is repaid by September 30 of the calendar year in which the advance was received, if the State receives no new advances during the period remaining in the calendar year following the repayment. If a State does receive additional loans during the period remaining in a calendar year after such a repayment, interest would be charged on the repaid loan from the date it was received until the date it was repaid.

Interest would be payable on the last day of the fiscal year in which the loan is received. The payment of interest on loans received in the last (5) five months of any fiscal year could be delayed

until the last day of the following fiscal year; however, interest at the rate specified above would be charged against the amount of interest for which payment was delayed. A State could *not* pay interest on Federal loans out of its unemployment trust fund.

3. *Non-FUTA Repayments*

Any non-FUTA State repayments (not including the lump sum repayment in lieu of the credit reduction in Item #2 above) would be credited first to the most recent loans received by the State that have not triggered a credit reduction.

4. *Expiration Date*

The limitation on credit reduction provisions are effective for the period October 1, 1981 through December 31, 1987. However, years in which a State qualified for a limitation on the credit reduction while these provisions were in effect would not count in determining the level of the credit reduction in years after the expiration of these provisions.

Interest would be charged on loans received during the period April 1, 1982 through December 31, 1987. States would be required to pay any interest that accrued during and after April 1, 1982 on loans received during this period.

7. *Certification of State unemployment laws (sec. 747 of the Senate amendment)*

Present law.—Under current law, a payroll tax of 3.4 percent on the first \$6,000 of wages paid to employees is levied on employers (Federal Unemployment Tax Act, FUTA). If a State's unemployment compensation program is certified by the Secretary of Labor as meeting certain requirements of Federal law, employers in that State receive a 2.7 percent credit against the 3.4 percent FUTA tax.

House bill.—No similar provision.

Senate amendment.—Prohibits certification by the Secretary of Labor of any State which has failed to amend its unemployment compensation law so that it contains provisions required to be included by this bill, including provisions of the Federal-State Extended Unemployment Compensation Act.

Delays for 1 year the effective dates of Senate amendment sections 741 and 742 for any State whose legislature does not meet at least 25 calendar days after the date of enactment and before September 25, 1981.

Delays for 1 year the effective dates of Senate amendment sections 743 and 744 for any State whose legislature does not meet at least 25 calendar days after the date of enactment and before September 25, 1982.

Conference Agreement.—House recedes with conforming amendments.

Finder's Aid
P.L. 97-123 (95 Stat. 1659) Approved December 29, 1981
"Amendment to the Omnibus Reconciliation Act of 1981"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>95 Stat.</u>	<u>H.C.Rep. 97-409</u>
Interfund Borrowing	201(i)	1(a)	1659	9
Minimum Benefit--Lump-Sum-- Effective Date	202(i)	2(j)(2) - (4)	1661	11
Repeal of Survivors Minimum Benefits--Effective Date	202(m)	2(j)(2) - (4)	1661	11
Continuation of Minimum Benefit for Existing Beneficiaries (Technical Amendment)	202(q)(4)	2(e)(1)	1660	—
Minimum Benefit--Actuarial Reductions--Effective Date	202(q)(4)	2(j)(2) - (4)	1661	11
Continuation of Minimum Benefit for Existing Beneficiaries (Technical Amendment)	202(q)(10)	2(e)(2)	1661	—
Minimum Benefit--Actuarial Reductions--Effective Date	202(q)(10)	2(j)(2) - (4)	1661	11
Minimum Benefit--Increase Due to Delayed Retirement--Effective Date	202(w)(1)	2(j)(2) - (4)	1661	—
Minimum Benefit--Increase Due to Delayed Retirement--Effective Date	202(w)(5)	2(j)(2) - (4)	1661	—
Continuation of Minimum Benefits for Existing Beneficiaries (Technical Amendment)	203(a)(8)	2(f)	1661	—
Minimum Benefit--Family Maximum-- Effective Date	203(a)(8)	2(j)(2) - (4)	1661	—
Penalties for Misuse of Social Security Numbers	208(g) Preceding (1)	4(a)(1)	1663	15
Altered or Counterfeited Social Security Cards	208(g)(3) New	4(a)(2)	1663	15
Penalties for Misuse of Social Security Numbers--Felony	208 Following subsection (h)	4(b)	1664	15

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>95 Stat.</u>	<u>H.C.Rep. 97-409</u>
Coverage of First Six Months of Sick Pay	209(b)(2)	3(a)	1662	12
Minimum Benefit--Primary Insurance Amount (PIA)--Effective Date	215(a)(1)(C) (i)	2(j)(2) - (4)	1661	11
Minimum Benefit--PIA-- Effective Date	215(a)(1)(C) (ii)	2(j)(2) - (4)	1661	11
Minimum Benefit--PIA-- Effective Date	215(a)(3)(A)	2(j)(2) - (4)	1661	11
Minimum Benefit--PIA-- Effective Date	215(a)(4)	2(j)(2) - (4)	1661	11
Continuation of Minimum Benefits for Existing Beneficiaries (Technical Amendment)	215(a)(5) First sentence	2(a)(1)(A)	1660	-
Minimum Benefit--PIA-- Effective Date	215(a)(5)	2(j)(2) - (4)	1661	11
Continuation of Minimum Benefits for Existing Beneficiaries (Technical Amendment)	215(a)(5) Last sentence	2(a)(1)(B)	1660	-
Minimum Benefit--PIA-- Effective Date	215(a)(5)	2(j)(2) - (4)	1661	11
Minimum Benefit--PIA-- Effective Date	215(a)(6)	2(j)(2) - (4)	1661	11
Continuation of Minimum Benefits for Existing Beneficiaries (Technical Amendment)	215(a)(6)(A)	2(a)(2)	1660	-
Minimum Benefit--Recomputations-- Effective Date	215(f)(7)	2(j)(2) - (4)	1661	-
Continuation of Minimum Benefit for Existing Beneficiaries-- Recomputations	215(f)(7) Second sentence	2(b)(1)	1660	-
Continuation of Minimum Benefit for Existing Beneficiaries-- Recomputations	215(f)(7) Last sentence	2(b)(2)	1660	-
Minimum Benefit--Recomputations-- Effective Date	215(f)(8)	2(j)(2) - (4)	1661	-

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>95 Stat.</u>	<u>H.C.Rep. 97-409</u>
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(2)(A)(ii)	2(j)(2) - (4)	1661	-
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(2)(A)(ii)(II)	2(j)(2) - (4)	1661	-
Continuation of Minimum Benefit for Existing Beneficiaries Cost-of-Living Increase	215(i)(2)(A)(iii)	2(c)	1660	-
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(2)(A)(iii)	2(j)(2) - (4)	1661	-
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(2)(A)(iv) and (v)	2(j)(2) - (4)	1661	-
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(2)(D)	2(j)(2) - (4)	1661	-
Continuation of Minimum Benefit for Existing Beneficiaries Cost-of-Living Increase	215(i)(4)	2(d)	1660	-
Minimum Benefit--Cost-of-Living Increase--Effective Date	215(i)(4)	2(j)(2) - (4)	1661	-
Continuation of Minimum Benefit for Existing Beneficiaries--Veterans	217(b)(1)	2(g)	1661	-
Minimum Benefits--Veterans--Effective Date	217(b)(1)	2(j)(2) - (4)	1661	-
Information with Respect to Prisoners	223(f)(3) New	6	1664	15
Minimum Benefits--Individual Agreements--Effective Date	233(c)(2)	2(j)(2) - (4)	1661	-
SSI--Benefits for Individuals Formerly Receiving Minimum Benefits Under Title II	1622 Repealed	2(h)	1661	11
Interfund Borrowing	1817(j) New	1(b)	1659	9

Public Law 97-123
97th Congress

An Act

To amend the Omnibus Reconciliation Act of 1981 to restore minimum benefits under the Social Security Act.

Dec. 29, 1981

[H.R. 4331]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Social Security
Act,
amendment.

INTERFUND BORROWING

SECTION 1. (a) Section 201 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 401.

“(1) If at any time prior to January 1983 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from the other such Trust Fund, or from the Federal Hospital Insurance Trust Fund established under section 1817, for transfer to and deposit in the Trust Fund whose need for financing is involved.

42 USC 1395i.

“(2) In any case where a loan has been made to a Trust Fund under paragraph (1), there shall be transferred from time to time, from the borrowing Trust Fund to the lending Trust Fund, interest with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (d).

Interest.

“(3) If in any month after a loan has been made to a Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

Repayments.

“(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.”.

Report to
Congress.

(b) Section 1817 of such Act is amended by adding at the end thereof the following new subsection:

42 USC 1395i.

“(j)(1) If at any time prior to January 1983 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

“(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred from time to time, from such Trust Fund to the lending Trust Fund, interest with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c).

Interest

Repayments.

“(3) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

Report to Congress.

“(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.”.

Effective date.
42 USC 401 note.

(c) The amendments made by this section shall be effective on the date of the enactment of this Act.

CONTINUATION OF MINIMUM BENEFITS FOR EXISTING BENEFICIARIES

Ante, p. 830.

SEC. 2. (a)(1) Section 215(a)(5) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended—

(A) in the first sentence, by striking out “, and the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be modified as specified in paragraph (6)”;

(B) in the last sentence, by striking out “, modified by the application of paragraph (6)”.

(2) Section 215(a)(6)(A) of the Social Security Act (as added by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is amended by striking out “The table of benefits” and all that follows down through “shall be extended” and inserting in lieu thereof the following “In applying the table of benefits in effect in December 1978 under this section for purposes of the last sentence of paragraph (4), such table, revised as provided by subsection (i), as applicable, shall be extended”.

(b) Section 215(f)(7) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended—

(1) by striking out the period at the end of the second sentence and inserting in lieu thereof “, and (effective January 1982) the recomputation shall be modified by the application of subsection (a)(6) where applicable.”; and

(2) by striking out the last sentence.

(c) Section 215(i)(2)(A)(iii) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended by inserting after “this title” the following: “and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) in the case of an individual to whom that subsection (as in effect in December 1981) applied, subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph (as then in effect)”.

(d) Section 215(i)(4) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended by striking out “, modified by the application of subsection (a)(6),” each place it appears.

Ante, p. 830.

(e) Section 202(q) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended—

(1) in paragraph (4), by striking out “changed” and “change” each place they appear and inserting in lieu thereof “increased” and “increase”, respectively; and

(2) in paragraph (10), by striking out “changed”, “change”, and “changes” each place they appear and inserting in lieu thereof “increased”, “increase”, and “increases”, respectively.

(f) Section 203(a)(8) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended by striking out “, modified by the application of section 215(a)(6).”

Ante, p. 830.

(g) Section 217(b)(1) of the Social Security Act (as amended by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is further amended by striking out “, and as modified by the application of section 215(a)(6).”

(h) Section 1622 of the Social Security Act (as added by section 2201 of the Omnibus Budget Reconciliation Act of 1981) is repealed.

Repeal.

(i) Subsection (e) of section 2201 of the Omnibus Budget Reconciliation Act of 1981 is repealed.

Ante, p. 830.

(j)(1) Subsection (h) of section 2201 of the Omnibus Budget Reconciliation Act of 1981 is repealed, effective September 1, 1981.

42 USC 415 note.

Ante, p. 830.

42 USC 1382 note.

(2) Except as provided in paragraphs (3) and (4), the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981 (other than subsection (f) thereof), together with the amendments made by the preceding subsections of this section, shall apply with respect to benefits for months after December 1981; and the amendment made by subsection (f) of such section 2201 shall apply with respect to deaths occurring after December 1981.

42 USC 415 note.

(3) Such amendments shall not apply—

(A) in the case of an old-age insurance benefit, if the individual who is entitled to such benefit first became eligible (as defined in section 215(a)(3)(B) of the Social Security Act) for such benefit before January 1982,

42 USC 415.

(B) in the case of a disability insurance benefit, if the individual who is entitled to such benefit first became eligible (as so defined) for such benefit before January 1982, or attained age sixty-two before January 1982,

(C) in the case of a wife's or husband's insurance benefit, or a child's insurance benefit based on the wages and self-employment income of a living individual, if the individual on whose wages and self-employment income such benefit is based is entitled to an old-age or disability insurance benefit with respect to which such amendments do not apply, or

(D) in the case of a survivors insurance benefit, if the individual on whose wages and self-employment income such benefit is based died before January 1982, or dies in or after January 1982 and at the time of his death is eligible (as so defined) for an old-age or disability insurance benefit with respect to which such amendments do not apply.

(4) In the case of an individual who is a member of a religious order (within the meaning of section 3121(r)(2) of the Internal Revenue Code of 1954), or an autonomous subdivision of such order, whose members are required to take a vow of poverty, and which order or subdivision elected coverage under title II of the Social Security Act before the date of the enactment of this Act, or who would be such a member except that such individual is considered retired because of old age or total disability, paragraphs (2) and (3) shall apply, except that each reference therein to “December 1981” or “January 1982” shall be considered a reference to “December 1991” or “January 1992”, respectively.

26 USC 3121.

42 USC 401.

EXTENSION OF COVERAGE TO FIRST SIX MONTHS OF SICK PAY

42 USC 409.

SEC. 3. (a) Clause (2) of section 209(b) of the Social Security Act is amended by inserting immediately after "sickness or accident disability" the following: "(but, in the case of payments made to an employee or any of his dependents, this clause shall exclude from the term 'wages' only payments which are received under a workmen's compensation law)".

26 USC 3121.

26 USC 3126.

(b)(1) Subparagraph (B) of section 3121(a)(2) of the Internal Revenue Code of 1954 (defining wages for purposes of the Federal Insurance Contributions Act) is amended to read as follows:

"(B) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this subparagraph shall exclude from the term 'wages' only payments which are received under a workmen's compensation law), or".

(2) Section 3121(a) of such Code is further amended by adding at the end thereof (after and below paragraph (18)) the following new sentence:

"Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (B) of paragraph (2) shall be treated for purposes of this chapter and chapter 22 as the employer with respect to such wages."

26 USC 3201 *et**seq.*

26 USC 3231.

26 USC 3233.

(c) Subsection (e) of section 3231 of such Code (defining compensation for purposes of the Railroad Retirement Tax Act) is amended by adding at the end thereof the following new paragraph:

"(4)(A) For purposes of applying sections 3201(b) and 3221(b) (and so much of section 3211(a) as relates to the rates of the taxes imposed by sections 3101 and 3111), in the case of payments made to an employee or any of his dependents on account of sickness or accident disability, clause (i) of the second sentence of paragraph (1) shall exclude from the term 'compensation' only—

"(i) payments which are received under a workmen's compensation law, and

45 USC 231t.

"(ii) benefits received under the Railroad Retirement Act of 1974.

45 USC 352.

"(B) Notwithstanding any other provision of law, for purposes of the sections specified in subparagraph (A), the term 'compensation' shall include benefits paid under section 2(a) of the Railroad Unemployment Insurance Act for days of sickness, except to the extent that such sickness (as determined in accordance with standards prescribed by the Railroad Retirement Board) is the result of on-the-job injury.

"(C) Under regulations prescribed by the Secretary, subparagraphs (A) and (B) shall not apply to payments made after the expiration of a 6-month period comparable to the 6-month period described in section 3121(a)(4).

"(D) Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in compensation solely by reason of subparagraph (A) or (B) shall be treated for purposes of this chapter as the employer with respect to such compensation."

26 USC 3121

note.

26 USC 3121.

Supra.

(d)(1) The regulations prescribed under the last sentence of section 3121(a) of the Internal Revenue Code of 1954, and the regulations prescribed under subparagraph (D) of section 3231(e)(4) of such Code, shall provide procedures under which, if (with respect to any employee) the third party promptly—

- (A) withholds the employee portion of the taxes involved,
- (B) deposits such portion under section 6302 of such Code, and
- (C) notifies the employer of the amount of the wages or compensation involved,

26 USC 6302.

the employer (and not the third party) shall be liable for the employer portion of the taxes involved and for meeting the requirements of section 6051 of such Code (relating to receipts for employees) with respects to the wages or compensation involved.

(2) For purposes of paragraph (1)—

Definitions.

(A) the term “employer” means the employer for whom services are normally rendered,

(B) the term “taxes involved” means, in the case of any employee, the taxes under chapters 21 and 22 which are payable solely by reason of the parenthetical matter contained in subparagraph (B) of section 3121(a)(2) of such Code, or solely by reason of paragraph (4) of section 3231(e) of such Code, and

26 USC 3101 *et seq.*, 3201 *et seq.*

(C) the term “wages or compensation involved” means, in the case of any employee, wages or compensation with respect to which taxes described in subparagraph (B) are imposed.

(e) For purposes of applying section 209 of the Social Security Act, section 3121(a) of the Internal Revenue Code of 1954, and section 3231(e) of such Code with respect to the parenthetical matter contained in section 209(b)(2) of the Social Security Act or section 3121(a)(2)(B) of the Internal Revenue Code of 1954, or with respect to section 3231(e)(4) of such Code (as the case may be), payments under a State temporary disability law shall be treated as remuneration for service.

26 USC 3121 note.
42 USC 409.
26 USC 3121.

(f) Notwithstanding any other provision of law, no penalties or interest shall be assessed on account of any failure to make timely payment of taxes, imposed by section 3101, 3111, 3201(b), 3211, or 3221(b) of the Internal Revenue Code of 1954 with respect to payments made for the period beginning January 1, 1982, and ending June 30, 1982, to the extent that such taxes are attributable to this section (or the amendments made by this section) and that such failure is due to reasonable cause and not to willful neglect.

26 USC 3101 note.

(g)(1) Except as provided in paragraph (2), this section (and the amendments made by this section) shall apply to remuneration paid after December 31, 1981.

26 USC 3101, 3111, 3201, 3211, 3221.

(2) This section (and the amendments made by this section) shall not apply with respect to any payment made by a third party to an employee pursuant to a contractual relationship of an employer with such third party entered into before December 14, 1981, if—

26 USC 3121 note.

(A) coverage by such third party for the group in which such employee falls ceases before March 1, 1982, and

(B) no payment by such third party is made to such employee under such relationship after February 28, 1982.

PENALTIES FOR MISUSE OF SOCIAL SECURITY NUMBERS

SEC. 4. (a) Section 208(g) of the Social Security Act is amended—

42 USC 408.

(1) by inserting “or for the purpose of obtaining anything of value from any person,” before “or for any other purpose” in the matter preceding paragraph (1); and

(2) by adding after paragraph (2) the following new paragraph:

“(3) knowingly alters a social security card issued by the Secretary, buys or sells a card that is, or purports to be, a card so issued, counterfeits a social security card, or possesses a social

security card or counterfeit social security card with intent to sell or alter it; or”.

42 USC 408.

(b) Section 208 of such Act is further amended by striking out “shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000 or imprisoned for not more than one year, or both” in the matter following subsection (h) and inserting in lieu thereof “shall be guilty of a felony and upon conviction thereof shall be fined not more than \$5,000 or imprisoned for not more than five years, or both”.

Effective date.
42 USC 408 note.

(c) The amendments made by subsections (a) and (b) shall be effective with respect to violations committed after the date of the enactment of this Act.

STATUTORY DEADLINE FOR IMPLEMENTING AFDC HOME HEALTH AIDE DEMONSTRATION PROJECTS

42 USC 632a.
Ante, p. 802.

SEC. 5. The last sentence of subsection (c)(2) of section 966 of the Omnibus Reconciliation Act of 1980 (as added by section 2156 of the Omnibus Budget Reconciliation Act of 1981) is amended by inserting “with at least seven States” after “agreements”.

INFORMATION WITH RESPECT TO PRISONERS

42 USC 423.

SEC. 6. Section 223(f) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

“(3) Notwithstanding the provisions of section 552a of title 5, United States Code, or any other provision of Federal or State law, any agency of the United States Government or of any State (or political subdivision thereof) shall make available to the Secretary, upon written request, the name and social security account number of any individual who is confined in a jail, prison, or other penal institution or correctional facility under the jurisdiction of such agency, pursuant to his conviction of an offense which constituted a felony under applicable law, which the Secretary may require to carry out the provisions of this subsection.”.

REPORT TO CONGRESS

SEC. 7. The Secretary of Health and Human Services shall report to the Congress within ninety days after the date of the enactment of this Act with respect to the actions being taken to prevent payments from being made under title II of the Social Security Act to deceased individuals, including to the extent possible the use of the death records available under the medicare program to screen the cash benefit rolls for such deceased individuals. 42 USC 401.

Approved December 29, 1981.

LEGISLATIVE HISTORY—H.R. 4331:

HOUSE REPORT No. 97-409 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 127 (1981):

July 31, considered and passed House.

July 31, Oct. 14, 15, considered and passed Senate, amended.

Dec. 15, Senate agreed to conference report.

Dec. 16, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 17, No. 53 (1981):

Dec. 29, Presidential statement.

SOCIAL SECURITY AMENDMENTS OF 1981

DECEMBER 14, 1981.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4331]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4331) to amend the Omnibus Reconciliation Act of 1981 to restore minimum benefits under the Social Security Act, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:.

INTERFUND BORROWING

SECTION 1. (a) Section 201 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(1) If at any time prior to January 1983 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from the other such Trust Fund, or from the Federal Hospital Insurance Trust Fund established under section 1817, for transfer to and deposit in the Trust Fund whose need for financing is involved.

"(2) In any case where a loan has been made to a Trust Fund under paragraph (1), there shall be transferred from time to time, from the borrowing Trust Fund to the lending Trust Fund, interest with respect to the unrepaid balance of such loan at a rate equal to

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4331) to amend the Omnibus Reconciliation Act of 1981 to restore minimum benefits under the Social Security Act, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

INTERFUND BORROWING

Present law.—The present law tax rates for OASDI and HI, and the allocation of the OASDI tax rate between OASI and DI are shown below. No authority exists for administratively transferring funds from one trust fund to another.

PRESENT LAW OASDHI TAX RATES

	OASI	DI	HI	Total
<i>Employees and employers, each (in percent):</i>				
1982	4.575	0.825	1.30	6.70
1983	4.575	.825	1.30	6.70
1984	4.575	.825	1.30	6.70
1985	4.750	.950	1.35	7.05
1986-89	4.750	.950	1.45	7.15
1990-2004	5.100	1.100	1.45	7.65
2005 and after	5.100	1.100	1.45	7.65
<i>Self-employed (in percent):</i>				
1982	6.8125	1.2375	1.30	9.350
1983	6.8125	1.2375	1.30	9.350
1984	6.8125	1.2375	1.30	9.350
1985	7.1250	1.4250	1.35	9.900
1986-89	7.1250	1.4250	1.45	10.000
1990-2004	7.6500	1.6500	1.45	10.750
2005 and after	7.6500	1.6500	1.45	10.750

House bill.—No provision.

Senate amendment.—Section 101 of the amendment would authorize borrowing between the OASI and DI trust funds at any time prior to January 1991. The Managing Trustee, the Secretary

of the Treasury, would determine when borrowing would be appropriate to meet the need to finance the benefit payments from these trust funds. The Managing Trustee would be authorized to borrow any amounts which he determines to be appropriate from either of these trust funds for transfer to and deposit in the other trust fund.

In any case where a loan had been made, interest would be paid by the borrowing fund to the lending fund at a rate equal to the rate the lending trust fund would earn on the unrepaid amount if the loan were a regular investment.

Whenever the Managing Trustee determined that the assets of the borrowing trust fund were sufficient to permit repayment of all, or part, of any loans made, he would make such repayments as he determines to be appropriate.

The Board of Trustees would be required to make a timely report to the Congress of any amounts borrowed or repaid (including interest payments).

Section 102 of the Senate amendment revises the distribution of social security taxes between the OASI, DI, and HI trust funds for 1982 and later, but did not alter the overall OASDHI combined tax rate under present law.

PROPOSED REALLOCATION OF OASDHI TAX RATES

	OASI	DI	HI	Total
Employees and employers, each (in percent):				
1982	5.185	0.715	0.80	6.70
1983	5.035	.665	1.00	6.70
1984	4.855	.595	1.25	6.70
1985	5.005	.595	1.45	7.05
1986-89	5.100	.600	1.45	7.15
1990-2004	5.150	.750	1.75	7.65
2005 and after	5.450	.750	1.45	7.65
Self-employed (in percent)				
1982	7.5150	1.0350	0.800	9.350
1983	7.3750	0.9750	1.000	9.350
1984	7.2150	0.8850	1.250	9.350
1985	7.5500	0.9000	1.450	9.900
1986-89	7.6500	0.9000	1.450	10.000
1990-2004	7.8550	1.1450	1.750	10.750
2005 and after	8.1750	1.1250	1.450	10.750

Conference agreement.—The conference agreement does not include the Senate provision with respect to changing the social security tax rates or the allocation of the OASDI tax rate between the OASI and DI trust funds. The conference agreement would authorize borrowing of existing assets between the OASI, DI, and HI trust funds under the same conditions and requirements as provided in the Senate amendment except with regard to effective date for borrowing between the OASI and DI trust funds. Under the conference agreement, the borrowing authority would be effective from the date of enactment through December 31, 1982. In determining that borrowing under this provision is appropriate in order to best meet the need for financing the benefit payments under any of the three trust funds, the Managing Trustee should, after consultation with the other trustees, make such determination no less frequently than on a monthly basis. In no case shall such interfund borrow-

ing make adjustments in the trust funds insuring benefit payments for a period more than six months beyond the date of such determination.

RESTORATION OF MINIMUM BENEFIT FOR CURRENT RECIPIENTS
(SECTION 2)

Present law.—The minimum benefit for all present and future beneficiaries will be eliminated. No person becoming eligible for old-age or disability benefits after October 1981 will be entitled to the minimum benefit. Benefits payable to new beneficiaries will be based on their actual earnings.

All other persons will be affected beginning with benefits payable for the month of March 1982. Their benefits will be recomputed based on their actual earnings record and according to recomputation procedures prescribed in regulations issued by the Secretary of HHS. In addition, persons aged 60 to 64 who are entitled to a minimum benefit for the month of February 1982 will become eligible for a special SSI benefit if they qualify under all SSI rules except that pertaining to age. The amount of the special SSI payment will be limited to the difference between the minimum benefit the individual received in February 1982 (without regard to the earnings test) and the recalculated benefit. These SSI payments will not be adjusted for increases in the cost of living, nor will these 60 to 64 year old persons become eligible for certain other benefits including State supplementation, food stamps, medicaid, or social services as a result of this provision.

This provision was adopted in section 2201 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-37).

House bill.—The House bill would repeal section 2201 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), thereby reinstating the OASDI minimum benefit provision as it existed under prior law for both current and future beneficiaries.

Senate amendment.—Section 103 of the amendment would restore the minimum benefit for all people who are eligible for benefits before November 1981 and who are residents of the 50 States, District of Columbia, Puerto Rico, Guam, Virgin Islands, and American Samoa. Among this group of beneficiaries, those with governmental pensions would, beginning with benefits for June of 1982, have their minimum benefit reduced dollar-for-dollar for the portion of their governmental pensions above \$300, but not below the amount of the benefit based on their actual earnings. This offset would apply only to the benefits of retired or disabled workers; it would not affect survivors' or dependents' benefits.

For members of religious orders who have taken a vow of poverty and who were first covered under the social security program prior to the date of enactment as a result of amendments adopted in 1972, the provision would apply the elimination of the minimum benefit for future recipients, only to those who become eligible after October 1991.

Conference agreement.—The conference agreement restores the minimum benefit for all people who are eligible for benefits before January 1982 or whose benefits are based on a worker's eligibility or death before January 1982. Also, the elimination of the minimum benefit for future recipients applies to members of religious orders who have taken a vow of poverty, who were first covered

under the social security program prior to the date of enactment, and who become eligible after October 1991.

For current recipients to whom the minimum benefit would be restored, the conference agreement does not include the provision of the Senate amendment that limits the restoration to residents of the United States and does not include the provision reducing the minimum benefit dollar-for-dollar for those also receiving governmental pensions above \$300.

EXTENSION OF COVERAGE TO FIRST SIX MONTHS OF SICK PAY—SECTION

3

Present law.—Payments made to or on behalf of an employee of a private employer on account of sickness or accident disability are subject to social security taxes and are treated as covered earnings *unless* they are either: (1) paid under a qualified plan or system; or (2) paid after the employee has not worked for the employer for more than six months. A qualified plan or system is one that applies to the employees of a firm generally or to a class or classes of employees. The existence of a plan or system is shown if the plan or system is in writing or is otherwise made known to employees (for example, through the medium of a bulletin board notice or the long and established practice of the employer). Other indications of the existence of a plan or system include, but are not limited to, contractual references to a plan or system, employer contributions to a plan, or segregated accounts for the payment of benefits.

With respect to railroad employment, the Railroad Retirement Tax Act, sec. 3201 et seq. of the Internal Revenue Code, excludes from taxable compensation the amount of any payment (including any amount paid by an employer for insurance or annuities) made to, or on behalf of, an employee or any of his dependents under a plan or system, on account of sickness or accident disability.

Under the Railroad Unemployment Insurance Act (sec. 2(a)) certain daily benefits are paid from the railroad unemployment insurance account for qualified employees for each day of sickness after the fourth consecutive day of sickness in a period of continuing sickness. In general, the daily benefit rate for such sickness is an amount equal to sixty percent of the employee's daily rate of compensation in a base year, but not less than \$12.70 nor in excess of \$25.00 per day. The maximum number of days of sickness within a benefit year for which benefits may be paid to an employee is one hundred and thirty (26 weeks). Under present law these sickness and disability benefits are not taxable compensation for railroad retirement tax purposes.

House bill.—No provision.

Senate amendment.—Section 104 of the amendment would remove the exclusion of certain sick pay received under a plan or system during the first six months the employee is off work. However, payments made by an insurance company would still be exempt unless the company is owned, to a substantial extent, by the employer, or the insurance company has an administrative-services-only contract with the employer under which the insurance company is reimbursed for sick payments actually made plus administrative expenses and profits. In addition, payments required by a workmen's compensation or temporary disability insurance law would continue to be exempt. This provision would be ef-

fective for sick payments made in January 1982 and thereafter. The treatment of payments made to an employee more than six months after the employee last worked would be unchanged from current law. Under the Senate amendment, sick payments made to employees covered by the railroad retirement system and sick pay benefits received under the Railroad Unemployment Insurance Act would continue to be exempt from railroad retirement employment taxes.

Conference agreement.—The conference agreement follows the Senate amendment extending coverage to certain forms of sick pay. In addition, the conference agreement would include in the definition of wages both for tax and coverage purposes, payments made under a sick pay plan to an employee or any of his dependents by a third party on account of the employee's illness. However, in the case where an employee has contributed to such plan, "wages" or "compensation" shall not include that portion of such payments attributable to the employee's contributions. It is the view of the conferees that such amounts are properly excludable in that they do not constitute remuneration for employment but rather represent a return on the premium contributions made by the employee. The conferees intend that rules similar to those provided in sec. 105 of the Internal Revenue Code (and regulations promulgated thereunder) shall apply in this instance. Payments which are received under a workmen's compensation law and those paid to an employee by either the employer or a third party more than six months after the employee last worked would continue to be excluded from the definition of wages, as under present law.

The conference agreement also provides that any third party (for example, an insurance company) that makes a payment, which is included in wages solely by reason of this provision, shall be treated as the employer with respect to such wages for purposes of social security and railroad retirement employment taxes. Thus, a third party payor will be responsible for the withholding of employee FICA taxes on wages up to the applicable maximum taxable wage base and for the remittance and timely deposit (as otherwise provided by law) of FICA taxes. However, the conference agreement establishes a specific statutory exception to this rule: the liability for the employer share of the FICA taxes will shift from the third party to the actual employer as soon as the third party payor has deposited the withheld employee taxes and notified the employer of the amount of sick pay made to the employee.

The conference agreement mandates the development of regulations which shall provide procedures under which, if the third party payor promptly withholds the employee portion of the taxes, deposits those taxes pursuant to the rules under section 6302 of the Code, and notifies the employer for whom services are usually rendered, of the payment, the employer (and not the third party payor) shall be liable for the employer portion of tax and for providing written statements and other reporting requirements under Code section 6051. It is the intention of the conferees that these regulations provide that third party payors withhold the employee portion of the tax as payments are made and deposit such withheld amounts under the applicable schedule authorized by Code section 6302 (including information reports such as Form 941 and related forms) as if these amounts were paid out of the third party payor's

own payroll. Further, the provision adopted by the conferees requires simultaneous notification of the employer of the amount of compensation paid to each employee. If these conditions are met, the liability for the employer portion of the payroll tax shifts from the party making the payments to the employer for whom services are normally rendered. Upon the employer's receipt of the notification of the payment made by the third party, such employer must deposit the appropriate employer taxes as if these payments were made out of his own payroll on that date. The conferees intend that the implementing regulations shall be promptly issued and that, having met the conditions specified in sec. 3(d), they will be relieved of the liability.

As a result, FICA and railroad retirement employment taxes on combined amounts in excess of the maximum taxable wage base could be withheld from employees and paid by employers. Under section 6413(c) of the Internal Revenue Code, employees who experience such overwithholding are eligible to receive refunds. The conferees expect that the Secretary will attempt to design procedures whereby employers and third party payors can avoid withholding on combined amounts in excess of the maximum taxable wage base (both for FICA and railroad retirement taxes) and will implement these procedures by regulation.

The conference agreement provides that, notwithstanding any other provision of law (including certain payments made under the Railroad Unemployment Insurance Act), compensation for purposes of the Railroad Retirement Tax Act shall include all payments made to an employee or any of his dependents on account of sickness or accident disability during the first six months the employee is off work except: payments which are received under a workmen's compensation law; payments which are received under The Railroad Retirement Act of 1974; or benefits which are paid under section 2(a) of the Railroad Unemployment Insurance Act for days of sickness to the extent that such sickness is the result of on-the-job injury (as determined in accordance with standards prescribed by the Railroad Retirement Board).

In addition, the conference agreement provides that, for purposes of the taxes imposed by this provision, payments made under a state temporary disability insurance law shall be treated as remuneration for service.

Under the conference agreement, no penalties or interest shall be assessed for failure to make timely payments of taxes with respect to payments of sick pay made between January 1, 1982 and June 30, 1982 and which are imposed as a result of amendments made by this section, to the extent that such failure is due to willful neglect and such taxes are paid on or before June 30, 1982.

Finally, the conference agreement provides generally that the amendments made by this section shall apply to remuneration paid after December 31, 1981. However, these amendments shall not apply to any third party payment made to an employee pursuant to a contractual relationship of an employer with such third party which is entered into before December 14, 1981, if the third party's coverage for that employee's group ceases before February 28, 1982 and no third party payment is made to such employee under that contract after February 28, 1982. Since such payments would not

be considered remuneration for purposes of these taxes, no employment taxes would be levied on such payments.

PENALTIES FOR MISUSE OF SOCIAL SECURITY NUMBERS (SECTION 4)

Present law.—Criminal penalties are provided for: (1) knowingly and willfully using a social security number that was obtained with false information, (2) using someone else's social security number, or (3) unlawfully disclosing or compelling the disclosure of someone else's social security number. The crime is considered a misdemeanor and the penalty involves a fine of up to \$1,000 or imprisonment for up to one year or both.

House bill.—No provision.

Senate amendment.—Section 110 of the amendment would add new acts considered to be a misuse of social security cards by making it unlawful to: (1) alter, (2) buy or sell, or (3) counterfeit social security cards, or (4) possess a regular or counterfeit card with intent to sell or alter it.

The provision would make all unlawful acts affecting the social security number or card a felony, rather than a misdemeanor.

It would increase the maximum fine for conviction of such acts from \$1,000 to \$5,000 and the maximum prison term from 1 year to 5 years.

Conference agreement.—The conference agreement follows the Senate amendment.

STATUTORY DEADLINE FOR IMPLEMENTING AFDC HOME HEALTH AIDE DEMONSTRATION PROJECTS (SECTION 5)

Present law.—P.L. 96-499 authorized the Secretary to enter into agreements with up to 12 States for the purpose of conducting demonstration projects to train AFDC recipients as homemaker-home health aides. This provision was amended by P.L. 97-35 to require the Secretary to establish by October 1, 1981, such guidelines and regulations as may be necessary to assure that agreements with the States are entered into by January 1, 1982.

House bill.—No provision.

Senate amendment.—Section 113 of the amendment would require the Secretary to meet the January 1, 1982 deadline for entering into demonstration agreements with at least 7 States.

Conference agreement.—The conference agreement follows the Senate amendment.

INFORMATION WITH RESPECT TO PRISONERS (SECTION 6)

Present law.—Beginning October 1980, disability insurance benefits cannot be paid while individuals are imprisoned for conviction of a felony, except where the individual is satisfactorily participating in a rehabilitation program which has been specifically approved for that individual by a court of law and which is expected to result in his being able to engage in substantial gainful activity upon release and within a reasonable period of time. Such individuals are also not eligible for student benefits. However, benefits can be paid to dependents of prisoners, just as if the prisoners were receiving benefits.

The law also provides that impairments, to the extent that they arise from, or are aggravated by, the commission of a crime, cannot be considered in determining whether a person is disabled, and im-

pairments arising while an individual is in prison cannot be considered for purposes of disability as long as the person remains in prison.

In order to implement this law, the Secretary of HHS requires information from penal institutions with which to identify the relevant prisoners. In some cases, providing this information without the consent of the prisoner possibly violates various privacy acts.

House bill.—No provision.

Senate amendment.—Section 108 of the amendment provides that, without regard to any contrary Federal or State law, Federal, State, or local government agencies must furnish the name and social security number of any prisoner convicted of a felony, when the Secretary of HHS makes a written request to the agency for the information.

Conference agreement.—The conference agreement follows the Senate amendment.

REPORT TO CONGRESS REGARDING PAYMENTS TO DECEASED PERSONS (SECTION 7)

Present law.—Social security benefits terminate with the month in which a beneficiary dies. Benefits are not payable for that month.

House bill.—No provision.

Senate amendment.—Section 109 of the amendment would require the Secretary of HHS to report to Congress within 90 days after enactment on actions being taken to prevent payments to deceased social security beneficiaries.

Conference agreement.—The conference agreement follows the Senate amendment.

OTHER PROVISIONS OF THE SENATE AMENDMENT

EXTENSION OF DISABILITY INSURANCE MAXIMUM FAMILY BENEFITS TO OLD-AGE AND SURVIVORS INSURANCE BENEFICIARIES

Present law.—There is a limit on the amount of monthly benefits that can be paid on the earnings record of one worker. This limit is known as the maximum family benefit (MFB). In retirement and survivor cases, the MFB ranges from 150 to 188 percent of the primary insurance amount, the unreduced benefit of the worker. In disability cases, the MFB can be no more than the lower of 85 percent of the worker's average indexed monthly earnings or 150 percent of the primary insurance amount, but not less than 100 percent of the primary insurance amount.

House bill.—No provision.

Senate amendment.—Section 105 of the amendment would provide that the disability maximum family benefit formula would be extended to retirement and survivor cases, for workers reaching age 62 or dying after December 1981.

Conference agreement.—The conference agreement does not include the Senate amendment.

STUDY OF SOCIAL SECURITY ADMINISTRATION EFFICIENCY

Present law.—Administrative expenses of the social security programs are paid out of trust fund monies. No provision of law re-

quires special or ongoing reports to Congress on the adequacy of the administrative capacity of the agency.

House bill.—No provision.

Senate amendment.—Section 106 of the amendment would require GAO to undertake a study of the SSA for the purpose of determining the management efficiency, employee productivity, and technical capacities (including computer hardware and programming) of that agency and the extent of current information on the characteristics of recipients. The Comptroller General would be required to report to Congress, no later than 180 days after the date of enactment, the results of the study and any recommendations for improvements in any of the operations studied.

Conference agreement.—The conference agreement does not include the Senate amendment.

SEPARATE ACCOUNTING FOR SOCIAL SECURITY TRUST FUNDS

Present law.—Reports on the receipts, outlays, surplus or deficit, and reserve balance of each of the social security trust funds are included in the President's annual budget. In addition, the Boards of Trustees publishes annual reports on the financial status of the trust funds and includes in the reports current estimates of the short-run and long-run actuarial balances of each trust fund.

House bill.—No provision.

Senate amendment.—Section 107 of the amendment would require the President, in the annual budget message and midsession review, to include a separate statement containing a summary of his requests for new budget authority and estimating outlays, revenues, and surplus or deficit of the OASI, DI, and HI trust funds. The separate statement would show the revenues, outlays, and surplus or deficit estimates for the trust funds, would describe the economic assumptions that were used in making the estimates for trust funds and the relationship to economic assumptions made for other parts of the budget, would indicate financial prospects of the trust funds, and would present a comparative summary of the three trust funds with all the other portions of the unified budget. This report would be in addition to the usual budget submission which includes the budget estimates for the trust funds within the unified budget estimates.

Conference agreement.—The conference agreement does not include the Senate amendment.

SOCIAL SECURITY CARDS

Present law.—Social security cards are issued on regular paper. No special procedures are employed to prevent alteration and duplication.

House bill.—No provision.

Senate amendment.—Section 111 of the amendment would require that new and replacement social security cards issued more than 190 days after enactment be made of bank-note paper and (to the maximum extent practicable) to be a card that cannot be counterfeited. The Secretary of HHS would be required to report his plans for implementing this provision within 90 days after enactment.

Conference agreement.—The conference agreement does not include the Senate amendment. The conferees, however, are aware

that the General Accounting Office has found that there may be a significant problem related to the use of counterfeit social security cards and believe that this matter deserves further consideration. The conferees believe that the Secretary of Health and Human Services should study the costs and benefits to the trust funds of such a proposal, the costs and benefits to other government programs, and the impact of such a proposal on the privacy of individuals.

FUTURE LEGISLATIVE CHANGES IN THE SOCIAL SECURITY ACT

Present law.—Congress has the authority to alter tax and spending provisions.

House bill.—No provision.

Senate amendment.—Section 112 of the amendment provides that it is the sense of the Congress that any future legislative changes in the Social Security Act will not reduce the current dollar amount of monthly OASDI benefits to which individuals are entitled for the month of enactment.

Conference agreement.—The conference agreement does not include the Senate amendment.

HIGHWAY TRUST FUND AND HIGHWAY EXCISE TAXES

Present law.—Under present law, the Highway Trust Fund and its related excise taxes are in place until October 1, 1984. At that time, the current rates of the excise taxes on gasoline and other motor fuels, on lubricating oil, on trucks and trailers, on truck parts and accessories, on tires, tubes and tread rubber and on the use of heavy trucks will expire or revert to prior lower rates. The provision authorizing the deposit of taxes to and appropriations from the Highway Trust Fund will also expire on October 1, 1984.

House bill.—No provision.

Senate amendment.—Sections 202 and 203 of the amendment would extend the highway excise taxes at current rates for 5 years, until October 1, 1989, but deposits of tax revenues to the Highway Trust Fund would be continued for 6 years, to October 1, 1990. Authorization for expenditures from the Highway Trust Fund would also be extended for 6 years, through September 30, 1990.

Conference agreement.—The conference agreement does not include the Senate amendment.

DAN ROSTENKOWSKI,
J. J. PICKLE,
CHARLES B. RANGEL
(except for section 3),
ANDREW JACOBS, Jr.,
RICHARD A. GEPHARDT,
BARBER B. CONABLE, Jr.,
WILLIS GRADISON,

Managers on the Part of the House.

BOB DOLE,
W. L. ARMSTRONG,
JOHN HEINZ,
RUSSELL LONG,
DANIEL MOYNIHAN,

Managers on the Part of the Senate.

Finder's Aid
P.L. 97-248 (96 Stat. 324) Approved September 3, 1982
"Tax Equity and Fiscal Responsibility Act of 1982"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H. Rep. 97-404</u>	<u>S. Rep. 97-494* Vol. 1</u>	<u>HCRep. 97-760**</u>
Employment--Real Estate Agents and Direct Sellers	210(p)	269(b)	552	--	--	650
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Entitlement to Medicare-- Dependency on Entitlement of Another Individual-- Effective Date (Technical Correction)	226(a)(2) note	128(c)(2)	367	--	--	--
Medicare Qualified Federal Employment (Technical Amendment)	226(a)(2)	278(b)(2)(A) (i)	560	--	--	--
Medicare Qualified Federal Employment (Technical Amendment)	226(a)(2)(A)	278(b)(2)(A) (ii)	560	--	--	--
Medicare Qualified Federal Employment (Technical Amendment)	226(a)(2)(B)	278(b)(2)(A) (iii)	560	--	--	--
Medicare Qualified Federal Employment-- Entitlement Over Age 65	226(a)(2)(C)	278(b)(2)(A) (iii)	560	--	378	657
Medicare Qualified Federal Employment-- Entitlement of Disabled (Technical Amendment)	226(b)(2)(B)	278(b)(2)(B) (i)	560	--	--	-
Medicare Qualified Federal Employment-- Entitlement of Disabled	226(b)(2)(C)	278(b)(2)(B) (i)	560	--	379	657
Medicare Qualified Federal Employment-- Clarification of Period of Entitlement	226(b)	278(b)(2)(B) (ii)	561	--	--	657

* No material relating to the Social Security Act in Vol. 2.

** Senate Conference Report 97-530 is identical.

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. 1</u>	<u>H.Rep. 97-760</u>
Medicare Based on Federal Employment-- Notice to Individuals (Technical Amendment)	226(g) Redesignated as (h)	278(b)(4)	561	--	--	--
Medicare Based on Federal Employment-- Notice to Individuals	226(g) New	278(b)(4)	561	--	--	658
Medicare Based on Federal Employment-- Entitlement of Individuals With End Stage Renal Disease	226A(a)(1)	278(b)(2)(C)	561	--	379	--
Child Support Enforce- ment (Technical Correction)	303(e)(2)(A) (i)	175(a)(2)	403	64	--	--
Child Support Enforce- ment (Technical Correction)	303(e)(2)(A) (iii)(II)	171(b)(3)	401	64	--	--
AFDC--Effective Date of Application (Technical Amendment)	402(a)(10) Redesignated as (10)(A)	152(a)(1)	396	--	--	--
AFDC--Effective Date of Application (Technical Amendment)	402(a)(10)(A)	152(a)(2)	396	--	--	--
AFDC--Effective Date of Application-- Protection of First Month's Benefit	402(a)(10)(B)	152(a)(3)	396	--	13, 43	444
AFDC--Rounding of Eligibility and Benefit Amounts (Technical Amendment)	402(a)(32)	151(a)(1)	395	--	--	--
AFDC--Rounding of Eligibility and Benefit Amounts (Technical Amendment)	402(a)(33)	151(a)(2)	395	--	--	--
AFDC--Job Search (Technical Amendment)	402(a)(33)	154(a)(1)	396	--	--	--
AFDC--Rounding of Eligibility and Benefit Amounts	402(a)(34)	151(a)(3)	395	--	13, 43	444

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. I</u>	<u>H.Rep. 97-760</u>
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AFDC--Job Search Program Participation	402(a)(35)	154(a)(3)	396	--	13, 45	445
AFDC--Payment to States-- Job Search Program Expenditures	403(a)(3)(C)	154(b)(1)	397	--	46	445
AFDC--Payment to States-- Job Search Program Expenditures (Technical Amendment)	403(a)(3) Following (C)	154(b)(2)	397	--	--	-
AFDC--Erroneous Assistance Expenditures (Technical Amendment)	403(a)(end)	156(b)	399	--	--	-
AFDC--Exclusion from Income of Certain State Payments	403(a)(end)	157(a)	399	--	13, 52	449
AFDC--Repeal of Child Screening Penalty (Technical Correction)	403(g)	137(a)(4)	376	--	--	-
AFDC--Federal Reimburse- ment for Erroneous Payments Limitation	403(i)	156(a)	398	--	13, 50	448
AFDC--Erroneous Payments--Applicability to Puerto Rico, Guam, the Virgin Islands, and the Northern Marianna Islands	403(j)	156(c)	399	--	--	451
AFDC--Absence from Home Due to Uniformed Service	406(a)(1)	153(a)	396	--	13, 44	444
AFDC--Job Search Program (Technical Amendment)	409(b)(3)	154(c)(1)(A)	397	--	--	-
AFDC--Job Search Program (Technical Amendment)	409(b)(3)	154(c)(1)(B)	397	--	--	-
AFDC--Job Search Program (Technical Amendment)	409(b)(3)	154(c)(1)(C)	397	--	--	-
AFDC--Job Search Program (Technical Amendment)	409(b)(3)	154(c)(2)	397	--	--	-

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. 1</u>	<u>H.C.Rep. 97-760</u>
AFDC--Family Living With Another Household-- Proration	412	155(a)	397	--	13, 49	448
AFDC--Extension of Time to Establish Work Incentive Demonstration Program	445(b)(1)	158(a)	399	--	13, 53	450
AFDC--Work Incentive Demonstration Program-- Waiver of Participation Criteria	445(b)(1)(B)	158(b)	399	--	--	450
Child Support Enforce- ment--IRS Collection (Technical Correction)	452(b)	175(a)(1)	403	--	--	-
Child Support Enforce- ment--Fee for Services (Technical Correction)	453(a)	171(b)(2)	401	--	--	-
Child Support Enforce- ment--Reimbursement of State Agency--1st Month of Ineligibility for AFDC	454(5)	173(a)	403	--	14, 55	453
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Child Support Enforce- ment--Costs in Excess of Fee	454(6)(C)	171(a)(3)	401	6, 34, 44, 49, 66	14, 54	452
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Child Support Enforce- ment--Costs in Excess of Fee (Technical Amendment)	454(19) Stricken	171(b)(1)(B)	401	66	--	-
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<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. I</u>	<u>HCRep. 97-760</u>
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Child Support Enforcement--Payment to States for Court Expenditures	455(c) Repealed	174(b)	403	--	--	--
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H. Rep. 97-404</u>	<u>S. Rep. 97-494 Vol. 1</u>	<u>H. Rep. 97-760</u>
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Unemployment Compensation--Tax Rate Increase	901(c)(3)(C)	271(c)(3)(D) (ii)	555	--	92, 376	--
Unemployment Compensation--Tax Rate Increase	901(c)(3)(C)	271(c)(3)(D) (iii)	555	--	92, 376	--
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Unemployment Compensation--Use of Amounts Transferred to State Accounts	903(c)(2)	192(a)(2)	408	5, 27, 44, 67	--	458
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<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. I</u>	<u>H.C.Rep. 97-760</u>
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<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. 1</u>	<u>HCRep. 97-760</u>
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<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. I</u>	<u>HCRep. 97-760</u>
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-404</u>	<u>S.Rep. 97-494 Vol. I</u>	<u>H.Rep. 97-760</u>
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PUBLIC LAW 97-248—SEPT. 3, 1982

**TAX EQUITY AND FISCAL RESPONSIBILITY
ACT OF 1982**



Public Law 97-248
97th Congress

An Act

Sept. 3, 1982

[H.R. 4961]

Tax Equity and
Fiscal
Responsibility
Act of 1982.

26 USC 1 note.

To provide for tax equity and fiscal responsibility, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; AMENDMENT OF 1954 CODE.

(a) **SHORT TITLE.**—This Act may be cited as the “Tax Equity and Fiscal Responsibility Act of 1982”.

(b) **TABLE OF CONTENTS.**—

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TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

Subtitle A—Medicare

PART I—CHANGES IN PAYMENTS FOR SERVICES

Subpart A—Amount of Payment for Institutional Services

- Sec. 101. Payment for inpatient hospital services.
- Sec. 102. Single reimbursement limit for skilled nursing facilities.
- Sec. 103. Elimination of inpatient routine nursing salary cost differential.
- Sec. 104. Elimination of duplicate overhead payments for outpatient services.
- Sec. 105. Single reimbursement limit for home health agencies.
- Sec. 106. Prohibiting payment for Hill-Burton free care.
- Sec. 107. Prohibiting payment for anti-unionization activities.
- Sec. 108. Reimbursement of provider-based physicians.
- Sec. 109. Prohibiting recognition of payments under certain percentage arrangements.
- Sec. 110. Elimination of lesser-of-cost-or-charge provision.
- Sec. 111. Elimination of private room subsidy.

Subpart B—Payments for Other Services

- Sec. 112. Reimbursement for inpatient radiology and pathology services.
- Sec. 113. Reimbursement for assistants at surgery.
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- Sec. 336. Jurisdiction of court and enforcement of summons in case of persons residing outside the United States.
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- Sec. 401. Short title.
- Sec. 402. Tax treatment of partnership items.
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TITLE V—AIRPORT AND AIRWAY IMPROVEMENT

- Sec. 501. Short title.
- Sec. 502. Declaration of policy.
- Sec. 503. Definitions.
- Sec. 504. National airport and airway system plans.
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- Sec. 521. Reports to Congress.
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- Sec. 523. Repeals; effective date; saving provisions; and separability.
- Sec. 524. Miscellaneous amendments.
- Sec. 525. Safety certification of airports.
- Sec. 526. Contracting authority.
- Sec. 527. Study of airport access.
- Sec. 528. Part-time operation of flight service stations.
- Sec. 529. Explosive detection K-9 teams.
- Sec. 530. Release of certain conditions.
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- Sec. 532. State taxation.

TITLE VI—FEDERAL SUPPLEMENTAL COMPENSATION PROGRAM

Subtitle A—Extension of Benefits

- Sec. 601. Short title.
- Sec. 602. Federal-State agreements.
- Sec. 603. Payments to States having agreements for the payment of Federal supplemental compensation.
- Sec. 604. Financing provisions.
- Sec. 605. Definitions.
- Sec. 606. Fraud and overpayments.

Subtitle B—Taxation of Unemployment Compensation

- Sec. 611. Taxation of unemployment compensation.

(c) AMENDMENT OF 1954 CODE.—Except as otherwise expressly provided, whenever in titles II, III, and IV an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954.

TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

Subtitle A—Medicare

PART I—CHANGES IN PAYMENTS FOR SERVICES

Subpart A—Amount of Payment for Institutional Services

PAYMENT FOR INPATIENT HOSPITAL SERVICES

SEC. 101. (a)(1) Title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

“PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

“SEC. 1886. (a)(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

42 USC 1395ww.

“(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

“(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

“(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

“(III) on or after October 1, 1984, is 110 percent.

“(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of

medical cases with respect to which such hospital provides services for which payment may be made under this title.

"(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

Cost reporting
period,
limitation.

"(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

"(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

"(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this title for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

"(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

"(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

"(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title, and

"(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

"(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

"(A) is located outside of a standard metropolitan statistical area, and

"(B)(i) has less than 50 beds, and

"(ii) was in operation and had less than 50 beds on the date of the enactment of this section.

"(4) For purposes of this section, the term 'operating costs of inpatient hospital services' includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services and such costs are determined on an average per admission or per discharge basis (as determined by the Secretary).

"(b)(1) Notwithstanding sections 1814(b) but subject to the provisions of sections 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital for a cost reporting period subject to this paragraph—

"(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

"Operating
costs of
inpatient
hospital
services."

42 USC 1395f.

42 USC 1395e.

“(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

“(ii) 5 percent of the target amount, whichever is less; or

“(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;

except that in no case may the amount payable under this title with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

“(2) Paragraph (1) shall not apply to cost reporting periods of hospitals beginning on or after October 1, 1985.

“(3)(A) For purposes of this subsection, the term ‘target amount’ means, with respect to a hospital for a particular 12-month cost reporting period—

“Target amount.”

“(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the preceding 12-month cost reporting period, and

“(ii) in the case a later reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

“(B) For purposes of subparagraph (A), the ‘applicable percentage increase’ for any 12-month cost reporting period shall be equal to 1 percentage point plus the percentage, estimated by the Secretary, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period exceeds the cost of such mix of goods and services for the preceding 12-month cost reporting period.

“Applicable percentage increase.”

“(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

“(B) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b).

“(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

“(6)(A) The Secretary shall provide for an adjustment under this paragraph in the amount of payment otherwise provided a hospital under this subsection in the case of a hospital which, as of August 15, 1982, was subject to the taxes (hereinafter in this paragraph referred to as the ‘FICA taxes’) imposed by section 3111 of the Internal Revenue Code of 1954 and which is not subject to such taxes for part or all of a cost reporting period beginning on or after October 1, 1982.

26 USC 3111.

Operating costs,
estimate.

“(B) In making such adjustment for a cost reporting period the Secretary shall estimate the amount of the operating costs of inpatient hospital services that would have resulted if the hospital was subject to the FICA taxes during that period. In making such estimate the Secretary shall reduce the amount of such FICA taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrates to the satisfaction of the Secretary were incurred in the period for pensions, health, and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under title II and this title of the Social Security Act.

42 USC 401.

“(C) If a hospital’s operating costs of inpatient hospital services estimated under subparagraph (B) is greater than the hospital’s operating costs of inpatient hospital services determined without regard to this paragraph for a cost reporting period, then the Secretary shall reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this subsection for the period by the amount by which—

“(i) the amount that would have been paid the hospital if (I) the amount of the operating costs of inpatient hospital services estimated under subparagraph (B) were treated as the amount of the operating costs of inpatient hospital services and (II) subsection (a) did not apply to the determination, exceeds—

“(ii) the amount that would otherwise have been paid the hospital if subsection (a) (and this paragraph) did not apply; except that, in making such determination for cost reporting periods beginning on or after October 1, 1984, clause (ii) of paragraph (1)(B) shall continue to apply.

“(c)(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

“(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State’s plan approved under title XIX;

“(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for

42 USC 1396.

inpatient hospital services, of hospital employees, and of hospital patients; and

“(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system.

“(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this title for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

“(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

“(A) determines that the system no longer meets the requirement of paragraph (1)(A) or

“(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) are not being (or will not be) met.”.

(2) Section 1861(v)(1)(L) of such Act is amended by striking out “(i)” and all that follows through “(ii)”.

(b)(1) The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1982.

(2)(A) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement such amendments on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than March 31, 1983.

(B) Chapter 35 of title 5, United States Code, shall not apply, until January 1, 1984, to collection of information and information collection requests which the Secretary of Health and Human Services determines to be necessary to carry out the amendments made by this section.

(3) Section 1135 of the Social Security Act is amended by adding at the end the following new subsection:

“(c) The Secretary shall develop, in consultation with the Senate Committee on Finance and the Committee on Ways and Means of the House of Representatives, proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers, would be reimbursed under title XVIII of this Act on a prospective basis. The Secretary shall report such proposals to such committees not later than December 31, 1982.”.

(c)(1) Section 1814(b) of the Social Security Act is amended—

(A) by striking out “section 1813” in the matter before paragraph (1) and inserting in lieu thereof “sections 1813 and 1886”; and

95 Stat. 798.

42 USC 1395x.

42 USC 1395ww
note.

Regulations.

5 USC 3501 *et*
seq.

42 USC 1320b-5.

42 USC 1395.
Report to
congressional
committees.
42 USC 1395f.

(B) by striking out “until the Secretary determines” in the second sentence and inserting in lieu thereof “until the first day of the seventh month beginning after the date the Secretary determines and notifies the Governor of the State”.

42 USC 1395l.

(2) Section 1833(a)(2)(B) of such Act is amended by inserting “and except as may be provided in section 1886” after “except those described in subparagraph (C) of this paragraph”.

42 USC 1395x.

(d) Section 1861(v)(7) of such Act is amended by inserting “(A)” after “(7)” and by adding at the end thereof the following new subparagraph:

“(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1886.”.

Ante, p. 331.

SINGLE REIMBURSEMENT LIMIT FOR SKILLED NURSING FACILITIES

SEC. 102. (a) Section 1861(v)(1) of the Social Security Act is amended—

42 USC 1395x.

(1) in subparagraph (E), by striking out “; except that” and all that follows and inserting in lieu thereof a period;

(2) in subparagraph (E), by striking out “(E)” and inserting in lieu thereof “(ii)”; and

(3) by inserting after subparagraph (D) the following:

“(E)(i) Such regulations shall provide that any determination of reasonable cost with respect to services provided by hospital-based skilled nursing facilities shall be made on the basis of a single standard based on the reasonableness of costs incurred by free standing skilled nursing facilities, subject to such adjustments as the Secretary may deem appropriate.”.

(b) The amendment made by subsection (a) shall be effective with respect to cost reporting periods beginning on or after October 1, 1982.

Effective date.
42 USC 1395x
note.

ELIMINATION OF INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL

SEC. 103. (a) Subparagraph (J) of section 1861(v)(1) of the Social Security Act is amended to read as follows:

“(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.”.

(b) The amendment made by subsection (a) shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act to a hospital or skilled nursing facility resulting from such amendment shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.

95 Stat. 797.
42 USC 1395x.

Effective date.
42 USC 1395x
note.

42 USC 1395.

ELIMINATION OF DUPLICATE OVERHEAD PAYMENTS FOR OUTPATIENT SERVICES

SEC. 104. (a) The last sentence of section 1842(b)(3) of the Social Security Act is amended by inserting after “1861(v)(1)(K)” the following: “, and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished

42 USC 1395u.

in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility".

(b) The amendment made by subsection (a) made by this section shall be effective with respect to services furnished on or after October 1, 1982.

Effective date.
42 USC 1395u
note.

SINGLE REIMBURSEMENT LIMIT FOR HOME HEALTH AGENCIES

SEC. 105. (a) Section 1861(v)(1)(L) of the Social Security Act, as amended by section 101(a)(2) of this subtitle, is amended by inserting "free standing" after "75th percentile of such costs per visit for".

42 USC 1395x.

(b) The amendment made by subsection (a) shall be effective with respect to cost reporting periods beginning on or after the date of the enactment of this Act.

Effective date.
42 USC 1395x
note.

PROHIBITING PAYMENT FOR HILL-BURTON FREE CARE

SEC. 106. (a) Section 1861(v)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

42 USC 1395x.

"(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs."

42 USC 291a,
300q.

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals.

Effective date.
42 USC 1395x
note.
42 USC 1395.

PROHIBITING PAYMENT FOR ANTI-UNIONIZATION ACTIVITIES

SEC. 107. (a) Section 1861(v)(1) of the Social Security Act, as amended by section 106(a) of this subtitle, is further amended by adding after subparagraph (M) the following new subparagraph:

"(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included."

(b) The amendment made by subsection (a) shall be effective with respect to costs incurred after the date of the enactment of this Act.

Effective date.
42 USC 1395x
note.

REIMBURSEMENT OF PROVIDER-BASED PHYSICIANS

SEC. 108. (a) Title XVIII of the Social Security Act is amended by adding after section 1886 of the Social Security Act (as added by section 101(a)(1) of this subtitle) the following new section:

"PAYMENT OF PROVIDER-BASED PHYSICIANS

"SEC. 1887. (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

42 USC 1395xx.

"(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an indi-

vidual patient, and which may be reimbursed as physicians' services under part B, and

"(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis.

"(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

"(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

"(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility."

(2) Section 1861(v)(7) of such Act, as amended by section 101(d) of this subtitle, is further amended by adding at the end the following new subparagraph:

"(C) For provisions restricting payment for provider-based physicians' services, see section 1887."

(c) The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act to a hospital or skilled nursing facility resulting from such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.

PROHIBITING RECOGNITION OF PAYMENTS UNDER CERTAIN PERCENTAGE ARRANGEMENTS

SEC. 109. (a) Section 1887 of the Social Security Act (as added by section 108(a) of this subtitle) is amended—

(1) by inserting "AND PAYMENT UNDER CERTAIN PERCENTAGE ARRANGEMENTS" at the end of its heading, and

(2) by adding at the end the following new subsection:

"(b)(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this title on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount

Ante, p. 336.

Ante, p. 337.

Regulations.
42 USC 1395xx
note.

Ante, p. 336.

42 USC 1395.

payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement.

"(2) Paragraph (1) shall not apply—

"(A) to services furnished by a physician and described in subsection (a)(1)(B) and covered by regulations in effect under subsection (a), and

"(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

"(i) is a customary commercial business practice, or

"(ii) provides incentives for the efficient and economical operation of the provider of services."

(b)(1) Section 1861(v)(1)(H)(iii) of such Act is amended by striking out "(I)" and by striking out ", or (II)" and all that follows through "furnished by the agency".

42 USC 1395x.

(2) Section 1861(v)(7)(C) of such Act, as added by section 108(b)(2) of this subtitle, is further amended by inserting "and for payments under certain percentage arrangements" after "services".

Ante, p. 338.

(c)(1) The amendments made by this section shall become effective on the date of the enactment of this Act, except that section 1887(b)(1) of the Social Security Act shall not apply before October 1, 1982, to services furnished by a physician and described in section 1887(a)(1)(B) of such Act.

Effective date.
42 USC 1395xx
note.
Ante, p. 337.

(2) In the case of a contract with a provider of services entered into prior to the date of the enactment of this Act, the amendment made by subsection (a) shall apply to payments under such contract (A) 30 days after the first date (after such date of enactment) the provider of services may unilaterally terminate the contract, or (B) one year after the date of the enactment of this Act, whichever is earlier.

(3) The amendment made by subsection (b)(1) shall not apply to contracts entered into before the date of the enactment of this Act.

42 USC 1395x
note.

ELIMINATION OF LESSER-OF-COST-OR-CHARGE PROVISION

SEC. 110. Section 1886 of the Social Security Act, as added by section 101(a)(1) of this subtitle, is amended by adding at the end the following new subsection:

Ante, p. 331.

"(d)(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this title. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this title for services provided by that class of provider.

"(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follows:

"(A) Clause (B) of paragraph (1) and paragraph (2) of section 1814(b).

42 USC 1395f.

42 USC 1395l.

“(B) So much of subparagraph (A) of section 1833(a)(2) as provides for payment other than of the reasonable cost of such services, as determined under section 1861(v).

42 USC 1395x.

“(C) Subclause (II) of clause (i) and clause (ii) of section 1833(a)(2)(B).”.

ELIMINATION OF PRIVATE ROOM SUBSIDY

42 USC 1395x
note.

SEC. 111. (a) The Secretary of Health and Human Services shall, pursuant to section 1861(v)(2) of the Social Security Act, not allow as a reasonable cost the estimated amount by which the costs incurred by a hospital or skilled nursing facility for nonmedically necessary private accommodations for medicare beneficiaries exceeds the costs which would have been incurred by such hospital or facility for semiprivate accommodations.

Regulations.

(b) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) as may be necessary to implement subsection (a) by October 1, 1982. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983.

Subpart B—Payments for Other Services

REIMBURSEMENT FOR INPATIENT RADIOLOGY AND PATHOLOGY SERVICES

42 USC 1395l.

SEC. 112. (a) Section 1833(a)(1) of the Social Security Act is amended—

(1) by striking out clause (B) and inserting in lieu thereof the following: “(B) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services,”;

(2) by inserting “and” at the end of clause (F); and

(3) by striking out “and (H)” and all that follows through “for such items and services,”.

(b) Clause (1) of section 1833(b) of such Act is amended to read as follows: “(1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10),”.

(c) The amendments made by this section shall apply with respect to items and services furnished on or after October 1, 1982.

Effective date.
42 USC 1395l
note.

REIMBURSEMENT FOR ASSISTANTS AT SURGERY

42 USC 1595u.

SEC. 113. (a) Section 1842(b)(6) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

“(D)(i) In the case of physicians’ services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), no payment shall be made under this part for services of assistants at surgery with respect to a surgical procedure if such hospital has a training program relating to the medical specialty required for such surgical procedure and a qualified individual on the staff of the hospital is available to provide such services; except that payment may be made under this part for such

42 USC 1395x.

services, to the extent that such payment is otherwise allowed under this paragraph, if such services, as determined under regulations of the Secretary—

“(I) are required due to exceptional medical circumstances,

“(II) are performed by team physicians needed to perform complex medical procedures, or

“(III) constitute concurrent medical care relating to a medical condition which requires the presence of, and active care by, a physician of another specialty during surgery,

and under such other circumstances as the Secretary determines by regulation to be appropriate.

“(ii) For purposes of this subparagraph, the term ‘assistant at surgery’ means a physician who actively assists the physician in charge of a case in performing a surgical procedure. “Assistant at surgery.”

“(iii) The Secretary shall determine appropriate methods of reimbursement of assistants at surgery where such services are reimbursable under this part.”

(b)(1) The amendment made by subsection (a) is effective with respect to services performed on or after October 1, 1982. Effective date. 42 USC 1395u note.

(2) The Secretary of Health and Human Services shall first issue such final regulations (whether on an interim or other basis) before October 1, 1982, as may be necessary to implement the amendment made by subsection (a) on a timely basis. If such regulations are promulgated on an interim final basis, the Secretary shall take such steps as may be necessary to provide opportunity for public comment, and appropriate revision based thereon, so as to provide that such regulations are not on an interim basis later than January 31, 1983.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 114. (a) Section 1876 of the Social Security Act is amended to read as follows: 42 USC 1395mm.

“PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

“SEC. 1876. (a)(1)(A) The Secretary shall annually determine—

“(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

“(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only. 42 USC 1395c, 1395j.

For purposes of this section, the term ‘risk-sharing contract’ means a contract entered into under subsection (g) and the term ‘reasonable cost reimbursement contract’ means a contract entered into under subsection (h).

Definitions.

“(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

“(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

“(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

“(E) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

“(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

“(3) Payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

“(4) For purposes of this section, the term ‘adjusted average per capita cost’ means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician’s service.

“(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

“(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1), and

“(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund.

“(6) If an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organi-

Ante, p. 335.
42 USC 1395l.

“Adjusted
average per
capita cost.”

42 USC 1395h,
1595u.

Post, p. 350.

42 USC 1395r.

zation shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

“(b) For purposes of this section, the term ‘eligible organization’ means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

“Eligible organization.”

“(1) is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), or

42 USC 300e-9.

“(2) meets the following requirements:

“(A) The entity provides to enrolled members at least the following health care services:

“(i) Physicians’ services provided by physicians (as defined in section 1861(r)(1)).

42 USC 1395x.

“(ii) Inpatient hospital services.

“(iii) Laboratory, X-ray, emergency, and preventive services.

“(iv) Out-of-area coverage.

“(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

“(C) The entity provides physicians’ services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

“(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in paragraph (1), except that such entity may—

“(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds \$5,000 in any year,

“(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

“(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

“(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

“(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under title XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

“(c)(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

“(2) The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(A) only those services covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

“(B) only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (i) the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (ii) in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

“(3)(A) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year, and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

“(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following a full calendar month after the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations.

“(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization.

“(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual

42 USC 1396.

42 USC 1301.

42 USC 1395c,
1395j.

because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

"(4) The organization must—

"(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, promptly as appropriate and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

"(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

"(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

"(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is \$1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the eligible organization shall be entitled to be parties to that judicial review.

42 USC 405.

"(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

"(d) Subject to the provisions of subsection (c)(3), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

42 USC 1395c,
1395j.

"(e)(1) In no case may—

"(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

"(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with

respect to services covered under part B) to individuals who are enrolled under this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.

“(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

“(A) the portion of such organization’s premium rate charged, with respect to such additional services, to members enrolled under this section, and

“(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services.

“(3) For purposes of this section, the term ‘adjusted community rate’ for a service or services means, at the election of an eligible organization, either—

“(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a ‘community rating system’ (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

“(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

“(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen’s compensation law or plan of the United States or a State, under an automobile or

42 USC 1395c,
1395j.

“Adjusted
community
rate.”

“Community
rating system.”

95 Stat. 575.
42 USC 300e.

liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

“(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

“(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

“(f)(1) Each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

42 USC 1396.

“(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only if the Secretary determines that—

Waiver.

“(A) special circumstances warrant such modification or waiver, and

“(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

“(g)(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b)(1), which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

Risk-sharing contract.

“(2) Each risk-sharing contract shall provide that—

Provisions.

“(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or

42 USC 1395c, 1395j.

“(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1)

at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

“(3) The additional benefits referred to in paragraph (2) are—

“(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this section, or

“(B) the provision of additional health benefits, or both.

“(h)(1) If—

“(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

“(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1),

the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3).

“(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

“(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

“(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization. If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

“(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in subsection (a)(1).

“(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

“(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in subsection

42 USC 1395x.

Anie, p. 331.

(a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

“(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

“(C) that in any case in which an eligible organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

Filing of a consolidated financial statement.

“(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

Distribution of profits.

“(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—

“(A) has failed substantially to carry out the contract,

“(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

“(C) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).

“(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

“(3) Each contract under this section—

“(A) shall provide that the Secretary, or any person or organization designated by him—

“(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

“(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

“(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

42 USC 300e-17.

42 USC 300e.

“(C) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members); and

“(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

“(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

“(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.”.

42 USC 1395x.

(b) Section 1861(s)(2) of the Social Security Act is amended—

(1) by striking out “and” at the end of subparagraph (F);

(2) by inserting “and” after the semicolon in subparagraph (G); and

(3) by adding after subparagraph (G) the following new subparagraph:

Ante, p. 341.

“(H) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(3)) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician’s service;”.

42 USC 1395mm
note.

(c)(1) Subject to paragraph (2), the amendment made by subsection (a) shall apply with respect to services furnished on or after the initial effective date (as defined in paragraph (4)), except that such amendment shall not apply—

(A) with respect to services furnished by an eligible organization to any individual who is enrolled with that organization under an existing cost contract (as defined in paragraph (3)(A)) and entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act at the time the organization first enters into a new risk-sharing contract (as defined in paragraph (3)(D)) unless—

42 USC 1395c,
1395j.

(i) the individual requests at any time that the amendment apply, or

(ii) the Secretary determines at any time that the amendment should apply to all members of the organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the eligible organization;

(B) with respect to services furnished by an eligible organization during the five-year period beginning on the initial effective date, if—

(i) the organization has an existing risk-sharing contract (as defined in paragraph (3)(B)) on the initial effective date, or

(ii) on the date of the enactment of this Act the organization was furnishing services pursuant to an existing demonstration project (as defined in paragraph (3)(C)), such demonstration project is concluded before the initial effective date, and before such initial effective date the organization enters into an existing risk-sharing contract, unless the organization requests that the amendment apply earlier; or

(C) with respect to services furnished by an eligible organization during the period of an existing demonstration project if on the initial effective date the organization was furnishing services pursuant to the project and if the project concludes after such date.

(2)(A) In the case of an eligible organization which has in effect an existing cost contract (as defined in paragraph (3)(A)) on the initial effective date, the organization may receive payment under a new risk-sharing contract with respect to a current, nonrisk medicare enrollee (as defined in subparagraph (C)) only to the extent that the organization enrolls, for each such enrollee, two new medicare enrollees (as defined in subparagraph (D)). The selection of those current nonrisk medicare enrollees with respect to whom payment may be so received under a new risk-sharing contract shall be made in a nonbiased manner.

(B) Subparagraph (A) shall not be construed to prevent an eligible organization from providing for enrollment, on a basis described in subsection (a)(6) of section 1876 of the Social Security Act (as amended by this Act, other than under a reasonable cost reimbursement contract), of current, nonrisk medicare enrollees and from providing such enrollees with some or all of the additional benefits described in section 1876(g)(2) of the Social Security Act (as amended by this Act), but (except as provided in subparagraph (A))—

Ante, p. 341.

(i) payment to the organization with respect to such enrollees shall only be made in accordance with the terms of a reasonable cost reimbursement contract, and

(ii) no payment may be made under section 1876 of such Act with respect to such enrollees for any such additional benefits. Individuals enrolled with the organization under this subparagraph shall be considered to be individuals enrolled with the organization for the purpose of meeting the requirement of section 1876(g)(2) of the Social Security Act (as amended by this Act).

(C) For purposes of this paragraph, the term “current, nonrisk medicare enrollee” means, with respect to an organization, an individual who on the initial effective date—

“Current, nonrisk medicare enrollee.”

(i) is enrolled with that organization under an existing cost contract, and

(ii) is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act.

42 USC 1395c, 1395j.

(D) For purposes of this paragraph, the term “new medicare enrollee” means, with respect to an organization, an individual who—

(i) is enrolled with the organization after the date the organization first enters into a new risk-sharing contract,

(ii) at the time of such enrollment is entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act, and

(iii) was not enrolled with the organization at the time the individual became entitled to benefits under part A, or to enroll in part B, of such title.

Definitions.

(3) For purposes of this subsection:

Ante, p. 341.

42 USC 1395f.

(A) The term "existing cost contract" means a contract which is entered into under section 1876 of the Social Security Act, as in effect before the initial effective date, or reimbursement on a reasonable cost basis under section 1833(a)(1)(A) of such Act, and which is not an existing risk-sharing contract or an existing demonstration project.

(B) The term "existing risk-sharing contract" means a contract entered into under section 1876(i)(2)(A) of the Social Security Act, as in effect before the initial effective date.

81 Stat. 930.

86 Stat. 1390.

42 USC 1395.

(C) The term "existing demonstration project" means a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, relating to the provision of services for which payment may be made under title XVIII of the Social Security Act.

(D) The term "new risk-sharing contract" means a contract entered into under section 1876(g) of the Social Security Act, as amended by this Act.

(E) The term "reasonable cost reimbursement contract" means a contract entered into under section 1833(a)(1) of the Social Security Act or under section 1876(h) of such Act, as amended by this Act.

(4) As used in this section, the term "initial effective date" means—

(A) the first day of the thirteenth month which begins after the date of the enactment of this Act, or

(B) the first day of the first month after the month in which the Secretary of Health and Human Services notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives that he is reasonably certain that the methodology to make appropriate adjustments (referred to in section 1876(a)(4) of the Social Security Act, as amended by this Act) has been developed and can be implemented to assure actuarial equivalence in the estimation of adjusted average per capita costs under that section,

whichever is later.

Study.

42 USC 1395mm
note.

Report to
Congress.

(d) The Secretary of Health and Human Services shall conduct a study of the additional benefits selected by eligible organizations pursuant to section 1876(g)(2) of the Social Security Act, as amended by subsection (a) of this section. The Secretary shall report to the Congress within 24 months of the initial effective date (as defined in subsection (c)(4)) with respect to the findings and conclusions made as a result of such study.

Study.

42 USC 1395mm
note.

(e) The Secretary of Health and Human Services shall conduct a study evaluating the extent of, and reasons for, the termination by medicare beneficiaries of their memberships in organizations with contracts under section 1876 of the Social Security Act. Such study may be coordinated with the study provided for under section 2178(d) of the Omnibus Budget Reconciliation Act of 1981. In conducting such study, the Secretary shall place special emphasis on the quantity and quality of medical care provided in such organizations and the quality of such care when provided on a fee-for-service

95 Stat. 813.

42 USC 1396a
note.

basis. The Secretary shall submit an interim report to the Congress, within two years after the initial effective date (as defined in subsection (c)(4)), and a final report within five years after such date containing the respective interim and final findings and conclusions made as a result of such study.

Report to
Congress.

PROHIBITION OF PAYMENT FOR INEFFECTIVE DRUGS

SEC. 115. (a) Effective September 30, 1982, section 131 of Public Law 97-92 is repealed, and the provisions of such section, and of section 210 of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Act, 1982 (H.R. 4560), as passed by the House of Representatives on October 6, 1981, and of section 209 of such Act as reported by the Senate Committee on Appropriations on November 9, 1981, shall not apply to any sums appropriated for fiscal year 1983 or any succeeding fiscal year.

Repeal.
95 Stat. 1199.

(b) No provision of law limiting the use of funds for purposes of enforcing or implementing section 1862(c) or section 1903(i)(5) of the Social Security Act, section 2103 of the Omnibus Budget Reconciliation Act of 1981, or any rule or regulation issued pursuant to any such section (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations) shall apply to any period after September 30, 1982, unless such provision of law is enacted after the date of the enactment of this Act and specifically states that such provision is to supersede this section.

42 USC 1395y
note.

42 USC 1862,
1956b.
42 USC 1395y.

Subpart C—Other Payment Provisions

MEDICARE PAYMENTS SECONDARY FOR OLDER WORKERS COVERED UNDER GROUP HEALTH PLANS

SEC. 116. (a) Section 4 of the Age Discrimination in Employment Act of 1967 is amended by adding at the end thereof the following new subsection:

29 USC 623.

“(g)(1) For purposes of this section, any employer must provide that any employee aged 65 through 69 shall be entitled to coverage under any group health plan offered to such employees under the same conditions as any employee under age 65.

“(2) For purposes of paragraph (1), the term ‘group health plan’ has the meaning given to such term in section 162(i)(2) of the Internal Revenue Code of 1954.”

“Group health
plan.”

26 USC 162.

(b) Section 1862(b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

42 USC 1395y.

“(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished during the period described in clause (iii) to an individual who is over 64 but under 70 years of age (or to the spouse of such individual, if the spouse is over 64 but under 70 years of age) who is employed at the time such item or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in clause (iv)) under which such individual is covered by reason of such employment.

“(ii) Any payment under this title with respect to any item or service during the period described in clause (iii) shall be condi-

tioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under a group health plan. The Secretary may waive the provisions of this clause in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

“(iii) The provisions of clauses (i) and (ii) shall apply to an individual only for the period beginning with the month in which such individual becomes entitled to benefits under this title under section 226(a) and ending with the month in which such individual attains the age of 70 and shall not include any month for which the individual would, upon application, be entitled to benefits under section 226A.

“(iv) For purposes of this paragraph, the term ‘group health plan’ has the meaning given to such term in section 162(i)(2) of the Internal Revenue Code of 1954.

“(B) Where payment for an item or service under a group health plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

“(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such group health plan; and

“(ii) such payment under this title, when combined with the amount payable under such plan, may not exceed—

“(I) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis; and

“(II) in the case of an item or service for which payment is authorized under this title on another basis, the greater of—

“(a) the amount which would be payable under the group health plan (without regard to deductibles and coinsurance under such plan), or

“(b) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title).”

(c) The amendment made by subsection (a) shall become effective on January 1, 1983, and the amendment made by subsection (b) shall apply with respect to items and services furnished on or after such date.

INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS

SEC. 117. (a)(1) Section 1815 of the Social Security Act is amended by adding at the end the following new subsection:

“(d) Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate deter-

“Waiver.”

42 USC 426.

42 USC 426-1.

“Group health plan.”

26 USC 162.

Ante, p. 331.

Effective date.
29 USC 623
note.

42 USC 1395g.

mined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.”.

(2) Section 1833 of such Act is amended by adding at the end the following new subsection: 42 USC 1395l.

“(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.”. 42 USC 1395u.

(b) The amendments made by subsection (a) apply to final determinations made on or after the date of the enactment of this Act. 42 USC 1395g note.

AUDIT AND MEDICAL CLAIMS REVIEW

SEC. 118. In addition to any funds otherwise provided for fiscal years 1983, 1984, and 1985 for payments to intermediaries and carriers under agreements entered into under sections 1816 and 1842 of the Social Security Act, there are transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Fund in such proportions as the Secretary of Health and Human Services determines to be appropriate, an additional \$45,000,000 for each of such fiscal years for payments to such intermediaries and carriers under such agreements to be used exclusively for the purpose of carrying out provider cost audits and reviews of medical necessity, consistent with the provisions of sections 1816 and 1842 of the Social Security Act. 42 USC 1395h note. 42 USC 1395h, 1395u.

PRIVATE SECTOR REVIEW INITIATIVE

SEC. 119. (a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVIII of the Social Security Act and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services. 42 USC 1395cc note. 42 USC 1395.

(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act, such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title, from collecting any payments from beneficiaries unless otherwise provided under such title.

TEMPORARY DELAY IN PERIODIC INTERIM PAYMENTS

SEC. 120. Notwithstanding section 1815(a) of the Social Security Act, in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that— 42 USC 1395g note. 42 USC 1395g.

(1) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1983, such payments shall be deferred until fiscal year 1984; and

(2) with respect to the last 21 days for which such payments would otherwise be made during fiscal year 1984, such payments shall be deferred until fiscal year 1985.

PART II—CHANGES IN BENEFITS, PREMIUMS, AND ENROLLMENT

MEDICARE COVERAGE OF FEDERAL EMPLOYEES

SEC. 121. For provisions providing certain employees of the United States and instrumentalities thereof with entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act, see section 278 of this Act.

Post, p. 559.

HOSPICE CARE

42 USC 1395c.

SEC. 122. (a)(1) Section 1811 of the Social Security Act is amended by striking out “and home health services” and inserting in lieu thereof “home health services, and hospice care”.

45 USC 231f.

(2) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by inserting “hospice care,” after “home health services.”

42 USC 1395d.

(b)(1) Section 1812(a) of the Social Security Act is amended by striking out “and” at the end of paragraph (2), by striking out the period at the end of paragraph (3) and inserting in lieu thereof “; and”, and by adding after paragraph (3) the following new paragraph:

“(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and one subsequent period of 30 days with respect to which the individual makes an election under subsection (d)(1).”

(2) Section 1812 of such Act is further amended by inserting after subsection (c) the following new subsection:

“(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and one subsequent period of 30 days during the individual’s lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

“(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

“(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

“(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

“(I) related to the treatment of the individual’s condition with respect to which a diagnosis of terminal illness has been made or

“(II) equivalent to (or duplicative of) hospice care; except that clause (ii) shall not apply to physicians’ services furnished by the individual’s attending physician (if not an employee of the hospice program) or to other than services provided by (or under arrangements made by) the hospice program.

“(B) After an individual makes such an election with respect to a 90- or 30-day period, the individual may revoke the election during the period, in which case—

“(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

“(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

“(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

“(D) For purposes of this title, an individual’s election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual’s revocation or change of election with respect to that election takes effect.”

(c)(1) Section 1814(a) of the Social Security Act is amended by striking out “and” at the end of paragraph (6), by striking out the period at the end of paragraph (7) and inserting in lieu thereof “; and”, and by inserting after paragraph (7) the following new paragraph:

42 USC 1395f.

“(8) in the case of hospice care provided an individual—

“(A)(i) in the first 90-day period—

“(I) the individual’s attending physician (as defined in section 1861(dd)(3)(B)), and

Post, p. 359.

“(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), and

“(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

“(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual’s attending physician and by the medical director (and the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program; and

“(C) such care is being or was provided pursuant to such plan of care.”

42 USC 1395f.

(2)(A) Section 1814(b) of such Act is amended by inserting "(other than a hospice program providing hospice care)" after "The amount paid to any provider of services".

(B) Section 1814 of such Act is further amended by adding at the end the following new subsection:

"PAYMENT FOR HOSPICE CARE

Post, p. 361.

"(i)(1) Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4), the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1861(v)(1)(A)), except that no payment may be for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

"(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program located in a region (as defined by the Secretary) for an accounting year may not exceed the 'cap amount' for the region for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

"Cap amount."

"(B) For purposes of subparagraph (A), the 'cap amount' for a region for a year is computed as follows:

"(i) The Secretary, using records of the program under this title, shall identify individuals (or a representative sample of such individuals)—

"(I) who died during the base period (as defined in clause (v)),

"(II) with respect to whom the primary cause of death was cancer, and

"(III) who, during the six-month period preceding death, were provided benefits under this title.

"(ii) The Secretary shall determine a national average medicare per capita expenditure amount by (I) determining (or estimating) the amount of payments made under this title with respect to services provided to individuals identified in clause (i) during the six months before death, and (II) dividing such amount of payments by the number of such individuals.

"(iii) The Secretary, using the best available data, shall then compute a regional average medicare per capita expenditure amount for each region, by adjusting the national average medicare per capita expenditure amount (computed under clause (ii)) to reflect the relative difference between that region's average cost of delivering health care and the national average cost of delivering health care.

"Cap amount."

"(iv) The 'cap amount' for a region for an accounting year is 40 percent of the regional average determined under clause (iii) for that region, increased or decreased by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the

Bureau of Labor Statistics, from the fourth month of the base period to the fifth month of the accounting year.

“(v) For purposes of this subparagraph, the term ‘base period’ means the most recent period of 12 months (ending before the date proposed regulations are first issued to carry out this paragraph) for which the Secretary determines he has sufficient data to make the determinations required under clauses (i) through (iii).”

“Base period.”

“(C) For purposes of subparagraph (A), the ‘number of medicare beneficiaries’ in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.”

“Number of medicare beneficiaries.”

(3) Section 1816(e) of such Act is amended by adding at the end thereof the following new paragraph:

42 USC 1395h.

“(5) Notwithstanding any other provision of this title, the Secretary shall designate the agency or organization which has entered into an agreement under this section to perform functions under such an agreement with respect to each hospice program, except that with respect to a hospice program which is a subdivision of a provider of services (and such hospice program and provider of services are under common control) due regard shall be given to the agency or organization which performs the functions under this section for the provider of services.”

(d)(1) Section 1861(u) of the Social Security Act is amended by inserting “hospice program,” after “home health agency,”.

42 USC 1395x.

(2) Section 1861(w)(1) of such Act is amended by striking out “or home health agency” and by inserting in lieu thereof “home health agency, or hospice program”.

(3) Section 1861 of such Act is further amended by adding at the end the following new subsection:

“HOSPICE CARE; HOSPICE PROGRAM

“(dd)(1) The term ‘hospice care’ means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual’s attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

“Hospice care.”

“(A) nursing care provided by or under the supervision of a registered professional nurse,

“(B) physical or occupational therapy or speech-language pathology,

“(C) medical social services under the direction of a physician,

“(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

“(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

“(F) physicians’ services,

“(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days, and

“(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

“Hospice program.”

“(2) The term ‘hospice program’ means a public agency or private organization (or a subdivision thereof) which—

“(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals,

“(ii) provides for such care and services in individuals’ homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

“(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), (F), and (H) of paragraph (1), and

“(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

“(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1812(d) with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

“(B) has an interdisciplinary group of personnel which—

“(i) includes at least—

“(I) one physician (as defined in subsection (r)(1)),

“(II) one registered professional nurse, and

“(III) one social worker,

employed by the agency or organization, and also includes at least one pastoral or other counselor,

“(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

“(iii) establishes the policies governing the provision of such care and services;

“(C) maintains central clinical records on all patients;

“(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

“(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

“(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

“(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

“(3)(A) An individual is considered to be ‘terminally ill’ if the individual has a medical prognosis that the individual’s life expectancy is 6 months or less.

“‘Terminally ill.’”

“(B) The term ‘attending physician’ means, with respect to an individual, the physician (as defined in subsection (r)(1)), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

“‘Attending physician.’”

“(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

“(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1866 and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this title.”

42 USC 1395cc.

(e) Section 1813(a) of such Act is amended by adding at the end the following new paragraph:

42 USC 1395e.

“(4)(A) The amount payable for hospice care shall be reduced—

“(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed \$5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

“(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

Ante, p. 358.

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term ‘hospice

“‘Hospice coinsurance period.’”

coinsurance period' means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(d) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

"(B) During the period of an election by an individual under section 1812(d)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished."

Ante, p. 356.

42 USC 1395y.

(f) Section 1862(a) of the Social Security Act is amended—

(1) by amending paragraph (1) to read as follows:

"(1)(A) which, except for items and services described in subparagraph (B) or (C), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

42 USC 1395x.

"(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness, and

"(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness;"

(2) by inserting "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))" in paragraph (6) after "comfort items";

(3) by striking out "paragraph (1)" in paragraph (7) and inserting in lieu thereof "paragraph (1)(B)"; and

(4) by inserting "(except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C))" in paragraph (9) after "custodial care".

42 USC 1395y.

(g)(1) Section 1862(f) of the Social Security Act is amended by striking out "paragraph (1)" and inserting in lieu thereof "paragraph (1)(A)".

42 USC 1395z.

(2) Section 1863 of the Social Security Act is amended by striking out "and (cc)(2)(I)" and inserting in lieu thereof "(cc)(2)(I), and (dd)(2)".

42 USC 1395aa.

(3) Section 1864(a) of such Act is amended—

(A) by inserting "or whether an agency is a hospice program" in the first sentence after "home health agency,"; and

(B) by striking out "or home health agency" in the second sentence and inserting in lieu thereof "home health agency, or hospice program".

42 USC 1395bb.

(4) Section 1865(a) of such Act is amended by striking out "or (o)" in the last sentence and inserting in lieu thereof "(o), or (dd)".

42 USC 1395cc.

(5) Section 1866(b)(2)(A) of such Act is amended by striking out "or (a)(3)" and inserting in lieu thereof "(a)(3), or (a)(4)".

(6) Section 1866(b)(4)(A) of such Act is amended by inserting "or hospice care" after "home health services".

42 USC 1395c
note.

(h)(1)(A) Subject to subparagraph (B), the amendments made by this section apply to hospice care provided on or after November 1, 1983, and before October 1, 1986.

(B) An individual who on October 1, 1986, has an election under section 1812(d)(1) of the Social Security Act in effect for a period, is entitled to hospice care benefits after that date during the remainder of that period and any consecutive period to which the individual would have been entitled before such date.

(2) In order to provide for the timely implementation of the amendments made by this Act, the Secretary of Health and Human Services shall, not later than September 1, 1983, promulgate such final regulations as may be necessary to set forth—

42 USC 1395f
note.

(A) a description of the care included in "hospice care" and the standards for qualification of a "hospice program", under section 1861(dd) of the Social Security Act, and

Ante, p. 359.

(B) the standards for payment for hospice care under part A of title XVIII of such Act, pursuant to section 1814(i) of such Act.

42 USC 1395;
Ante, p. 358.

(h)(1) Notwithstanding any provision of law which has the effect of restricting the time period of a hospice demonstration project in effect on July 15, 1982, pursuant to section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of the project until November 1, 1983, or, if later, the date on which payments can first be made to any hospice program under the amendments made by this section.

42 USC 1395b-1
note.

81 Stat. 930.

(2) Prior to September 30, 1983, the Secretary shall submit to Congress a report on the effectiveness of demonstration projects referred to in paragraph (1), including an evaluation of the cost-effectiveness of hospice care, the reasonableness of the 40-percent cap amount for hospice care as provided in section 1814(i) of the Social Security Act (as added by this section), proposed methodology for determining such cap amount, proposed standards for requiring and measuring the maintenance of effort for utilizing volunteers as required under section 1861(dd) of such Act, an evaluation of physician reimbursement for services furnished as a part of hospice care and for services furnished to individuals receiving hospice care but which are not reimbursed as a part of the hospice care, and any proposed legislative changes in the hospice care provisions of title XVIII of such Act.

Report to
Congress.

(i)(1) The Secretary of Health and Human Services shall conduct a study and, prior to January 1, 1986, report to the Congress on whether or not the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act are fair and equitable and promote the most efficient provision of hospice care. Such report shall include the feasibility and advisability of providing for prospective reimbursement for hospice care, an evaluation of the inclusion of payment for outpatient drugs, an evaluation of the need to alter the method of reimbursement for nutritional, dietary, and bereavement counseling as hospice care, and any recommendations for legislative changes in the hospice care reimbursement or benefit structure.

42 USC 1395.
Study; report to
Congress.
42 USC 1395f
note.

(2) The Comptroller General shall monitor and evaluate the study and the preparation of the report under paragraph (1).

(j) The Secretary of Health and Human Services shall grant waivers of the limitations imposed by section 1814(i)(2) of the Social Security Act (relating to the cap amount), section 1861(dd)(1)(G) of such Act (relating to the limitations on the frequency and number of respite care days), and section 1861(dd)(2)(A)(iv) of such Act (relating to the aggregate limit on the number of days of inpatient care), as may be necessary to allow any institution which commenced operations as a hospice prior to January 1, 1975, to participate until October 1, 1986, in a viable manner as a hospice program under title XVIII of the Social Security Act.

Waivers.
42 USC 1395f
note.

COVERAGE OF EXTENDED CARE SERVICES WITHOUT REGARD TO THREE-DAY PRIOR HOSPITALIZATION REQUIREMENT

42 USC 1395d.

SEC. 123. (a) Section 1812(a)(2) of the Social Security Act is amended by inserting "(A)" after "(2)" and by inserting before the semicolon at the end the following: ", and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services".

(b) Section 1812 of such Act is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

"(2) The Secretary may provide—

"(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

"(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1)."

42 USC 1395f,
1395x; *Ante*,
p. 331.

PROVISION TEMPORARILY HOLDING PART B PREMIUM AT CONSTANT PERCENTAGE OF COST

42 USC 1395r.

SEC. 124. (a)(1) Section 1839(c)(2) of the Social Security Act is amended by striking out "except as provided in subsection (d)" and inserting in lieu thereof "except as provided in subsections (d) and (g)".

(2) Section 1839(c)(3) of such Act is amended by inserting "(except as otherwise provided in subsection (g))" after "The monthly premium shall".

(b) Section 1839 of such Act is amended by adding at the end thereof the following new subsection:

"(g)(1) Notwithstanding the provisions of subsection (c), the monthly premium for each individual enrolled under this part for each month after June 1983 and prior to July 1985 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (c)(1) and applicable to such month.

"(2) Any increases in premium amounts taking effect prior to July 1985 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (c)(3)."

42 USC 1395w.

(c) Section 1844(a)(1) of such Act is amended by striking out "section 1839(c)(3)" each place it appears in subparagraphs (A)(i) and (B)(i) and inserting in lieu thereof in each instance "section 1839(c)(3) or 1839(g), as the case may be".

Supra.

SPECIAL ENROLLMENT PROVISIONS FOR MERCHANT SEAMEN

SEC. 125. (a) Any individual who—

(1) was entitled to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act (as in effect on September 30, 1981), including such entitlement on the basis of continuing medical care under 42 C.F.R. § 32.17, at any time during the period beginning on March 10, 1981, and ending on October 1, 1981, and

(2) as of September 30, 1981, was eligible under section 1818(a) or section 1836 of the Social Security Act to enroll in the insurance program established by part A or part B, respectively, of title XVIII of that Act (hereinafter in this section referred to as the “respective program”),

may enroll (if not otherwise enrolled) in the respective program during the period beginning on the first day of the first month beginning at least 20 days after the date of the enactment of this Act and ending on December 31, 1982.

(b)(1) The coverage period under the respective program of an individual who enrolls under subsection (a) shall begin—

(A) on the first day of the month following the month in which the individual enrolls, or

(B) on October 1, 1981, if the individual files a request for this subparagraph to apply and pays the monthly premiums for the months so covered.

(2) The coverage period under the respective program of an individual described in subsection (a) who enrolled in the respective program before the enrollment period described in that subsection shall be retroactively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

(c)(1) For purposes of section 1839(d) of the Social Security Act with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

(2) Paragraph (1) shall not apply to an individual—

(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act, shall provide for the dissemination of information—

(A) to unions and other associations representing or assisting seamen,

(B) to offices enrolling individuals under the respective programs, and

(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section,

concerning the special benefits provided under this section.

42 USC 1395i-2
note.

95 Stat. 603.
42 USC 249.

42 USC 1395i-2,
1395o.

42 USC 1395c,
1395j.

42 USC 1395r.

(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act (as in effect before October 1, 1981) by providing—

(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

(B) the individual's seamen's papers covering that date, or

(C) such other reasonable documentation as the Secretary may require.

PART III—MISCELLANEOUS PROVISIONS

EXTENDING MEDICARE PROFICIENCY EXAMINATION AUTHORITY

SEC. 126. Section 1123(a) of the Social Security Act is amended by striking out "December 31, 1981" and inserting in lieu thereof "September 30, 1983".

REGULATIONS REGARDING ACCESS TO BOOKS AND RECORDS

SEC. 127. Section 952 of the Omnibus Reconciliation Act of 1980 (94 Stat. 2646) is amended—

(1) by inserting "(a)" after "Sec. 952.", and

(2) by adding at the end the following new subsection:

"(b) Unless the Secretary of Health and Human Services first publishes final regulations prescribing the criteria and procedures described in the last sentence of section 1861(v)(1)(I) of the Social Security Act by January 1, 1983, after providing a period of not less than 60 days for public comment on proposed regulations, the amendment made by subsection (a) shall only apply to books, documents, and records relating to services furnished (pursuant to contract or subcontract) on or after the date on which final regulations of the Secretary are first published."

TECHNICAL CORRECTIONS TO OMNIBUS BUDGET RECONCILIATION ACT OF 1981

SEC. 128. (a)(1) Section 1861(cc)(1) of the Social Security Act is amended, in the matter following subparagraph (H), by striking out "outpatient" and inserting in lieu thereof "inpatient".

(2) The second sentence of section 1862(b)(1) of such Act is amended by striking out "or plan".

(3) Section 1862(b)(2)(A) of such Act is amended by striking out "section 162(h)(2)" and inserting in lieu thereof "section 162(i)(2)".

(4) The first sentence of section 1862(b)(2)(B) of such Act is amended by inserting "furnished" before "to an individual".

(5) Section 1866(b) of such Act is amended by striking out "(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1))" in the matter preceding paragraph (1).

(6) The second subsection (c) of section 1884 of such Act is redesignated as subsection (d).

(b) Section 162 of the Internal Revenue Code of 1954 is amended—

(1) by redesignating the subsection (i) (relating to cross reference), as redesignated by the Economic Recovery Tax Act of 1981 (Public Law 95-34), as subsection (j), and

(2) by redesignating the subsection (h) (relating to group health plans), as added by section 2146(b) of the Omnibus Budget Reconciliation Act of 1981, as subsection (i).

(c)(1) Section 2143(b)(1) of the Omnibus Budget Reconciliation Act of 1981 is amended by striking out "costs" and inserting in lieu thereof "cost".

(2) Section 2203(f)(3) of such Act is amended by striking out "August 1982" and inserting in lieu thereof "August 1981".

(d)(1) Sections 1842(b)(3)(B)(ii)(II) and 1870(c) of the Social Security Act are each amended by striking out "1862" and inserting in lieu thereof "1862(a)".

(2) The final subparagraph (C) of section 1861(e) of such Act is amended by striking out "may (i)," and inserting in lieu thereof "(i) may".

(3) Section 1865(b) of such Act is amended by striking out "an institution" and "such institution" and inserting in lieu thereof "a hospital" and "the hospital", respectively.

(4) Section 1866(a)(1)(B) of such Act is amended by inserting "of section 1862(a)" after "(1) or (9)".

(e)(1) Any amendment to the Omnibus Budget Reconciliation Act of 1981 made by this section shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

(2) Except as otherwise provided in this section, any amendment to the Social Security Act or the Internal Revenue Code of 1954 made by this section (other than subsection (d)) shall be effective as if it had been originally included as a part of that provision of the Social Security Act or Internal Revenue Code of 1954 to which it relates, as such provision of such Act or Code was amended by the Omnibus Budget Reconciliation Act of 1981.

(3) The amendments made by subsection (d) shall take effect upon enactment.

95 Stat. 800.

95 Stat. 798.

42 USC 1395x
note.

95 Stat. 835.

42 USC 1395u,
1395gg.

42 USC 1395x.

42 USC 1395bb.

42 USC 1395cc.

Effective date.

42 USC 1395x
note.

95 Stat. 357.

42 USC 1305; 26
USC 1.

Effective date.

Subtitle B—Medicaid

COPAYMENTS BY MEDICAID RECIPIENTS

SEC. 131. (a) Section 1902(a)(14) of the Social Security Act is amended to read as follows:

42 USC 1396a.

"(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916;"

(b) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

42 USC 1396.

"USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

"SEC. 1916. (a) The State plan shall provide that in the case of individuals described in section 1902(a)(10)(A) who are eligible under the plan—

42 USC 1396o.
95 Stat. 807.

"(1) no enrollment fee, premium, or similar charge will be imposed under the plan;

"(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

“(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

“(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

“(C) services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, or

“(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled; and

“(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ‘nominal’ under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

“(b) The State plan shall provide that in the case of individuals other than those described in section 1902(a)(10)(A) who are eligible under the plan—

“(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual’s income,

“(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

“(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

“(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

“(C) services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution, if such individual

42 USC 1396d.

42 USC 1396b.

95 Stat. 807.

42 USC 1396a.

is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, or

“(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled; and

42 USC 1396d.

42 USC 1396b.

“(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ‘nominal’ under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

“(c) The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual’s inability to pay a deduction, cost sharing, or similar charge. The requirements of this subparagraph shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

“(d) No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary unless authorized under this section, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

“(1) will test a unique and previously untested use of copayments,

“(2) is limited to a period of not more than two years,

“(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

“(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

“(5) in which participation is voluntary, or in which provision is made for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.”.

(b) Section 1902(a)(10) of such Act is amended in the matter following subparagraph (D)—

42 USC 1396a.

(1) by striking out “and” before “(III)”; and

(2) by inserting before the semicolon at the end thereof the following: "and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption".

Ante, p. 367.

Effective date.
42 USC 1396o
note.

42 USC 1396.

(c)(1) Except as provided in paragraph (2), the amendments made by this section shall become effective on October 1, 1982.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

MODIFICATIONS IN LIEN PROVISIONS

42 USC 1396a.

SEC. 132. (a) Section 1902(a)(18) of the Social Security Act is amended to read as follows:

Infra.

"(18) comply with the provisions of section 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets;"

(b) Title XIX of such Act is amended by adding after section 1916 (added by section 131 of this Act) the following new section:

"LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

42 USC 1396p.

"SEC. 1917. (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

"(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(B) in the case of the real property of an individual—

"(i) who is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

"(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

"(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

"(A) the spouse of such individual,

"(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to

42 USC 1301.

participate in such program) is blind or disabled as defined in section 1614, or

42 USC 1382c.

“(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual’s home for a period of at least one year immediately before the date of the individual’s admission to the medical institution), is lawfully residing in such home.

“(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual’s discharge from the medical institution and return home.

“(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except—

“(A) in the case of an individual described in subsection (a)(1)(B), from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

“(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate.

“(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual’s surviving spouse, if any, and only at a time—

“(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614; and

42 USC 1381.

“(B) in the case of a lien on an individual’s home under subsection (a)(1)(B), when—

“(i) no sibling of the individual (who was residing in the individual’s home for a period of at least one year immediately before the date of the individual’s admission to the medical institution), and

“(ii) no son or daughter of the individual (who was residing in the individual’s home for a period of at least two years immediately before the date of the individual’s admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home and has lawfully resided in such home on a continuous basis since the date of the individual’s admission to the medical institution.

“(c)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act, and which may provide for a waiver of denial of such assistance in any instance where the State determines that such denial would work an undue hardship.

42 USC 1382b.

“(2)(A) In any case where the uncompensated value of disposed of resources exceeds \$12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

“(B)(i) In the case of any individual who is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and, who, at any time during or after the 24-month period immediately prior to application for medical assistance under the State plan, disposed of a home for less than fair market value, the State plan (subject to clause (iii)) may provide for a period of ineligibility for medical assistance in accordance with clause (ii).

“(ii) If the State plan provides for a period of ineligibility under clause (i), such plan—

“(I) shall provide that such individual shall be ineligible for all medical assistance for a period of 24 months after the date on which he disposed of such home, except that, in the case where the uncompensated value of the home is less than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, the period of ineligibility shall be such shorter time as bears a reasonable relationship (based upon the average amount payable under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home, and

“(II) may provide (at the option of the State) that, in the case where the uncompensated value of the home is more than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, such individual shall be ineligible for all medical assistance for a period in excess of 24 months after the date on which he disposed of such home which bears a reasonable relationship (based upon the average amount payable under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home.

“(iii) An individual shall not be ineligible for medical assistance by reason of clause (ii) if—

“(I) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual cannot reasonably be expected to be discharged from the medical institution and to return to that home,

“(II) title to such home was transferred to the individual's spouse or child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

“(III) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the home either at fair market value, or for other valuable consideration, or

“(IV) if the State determines that denial of eligibility would work an undue hardship.

“(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).”

42 USC 1382b.

(c) Section 1902 of such Act is amended by striking out subsection (j) thereof.

42 USC 1396a.

(d) The amendments made by this section shall become effective on the date of the enactment of this Act, but the provisions of section 1917(c)(2)(B) of the Social Security Act shall not apply with respect to a transfer of assets which took place prior to such date of enactment.

Effective date.
42 USC 1396p
note.
Ante, p. 370.

LIMITATION OF FEDERAL FINANCIAL PARTICIPATION IN ERRONEOUS MEDICAL ASSISTANCE EXPENDITURES

SEC. 133. (a) Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 1396b.

“(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State’s erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

“(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

Waiver.

“(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

“(D)(i) For purposes of this subsection, the term ‘erroneous excess payments for medical assistance’ means the total of—

“Erroneous excess payments for medical assistance.”

“(I) payments under the State plan with respect to ineligible individuals and families, and

“(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

“(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the

difference between the actual amount of such resources and the allowable resource level established under the State plan.

"(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

"(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

"(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

"(ii) payments made as the result of a technical error.

"(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

"(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

"(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

"(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa."

(b) The amendment made by subsection (a) shall become effective on the date of the enactment of this Act.

(c) No provision of law limiting Federal financial participation with respect to erroneous payments made by States under a State plan approved under title XIX of the Social Security Act (including any provision contained in, or incorporated by reference into, any appropriation Act or resolution making continuing appropriations), other than the limitations contained in section 1903 of such Act, shall be effective with respect to payments to States under such section 1903 for quarters beginning on or after October 1, 1982, unless such provision of law is enacted after the date of the date of the enactment of this Act and expressly provides that such limitation is in addition to or in lieu of the limitations contained in section 1903 of the Social Security Act.

Effective date.

12 USC 1396b

note.

12 USC 1396b

note.

12 USC 1396.

2 USC 1396b.

MEDICAID COVERAGE OF HOME CARE FOR CERTAIN DISABLED CHILDREN

SEC. 134. (a) Section 1902(e) of the Social Security Act is amended by adding at the end the following new paragraph: 42 USC 1396a.

“(3) At the option of the State, any individual who—

“(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a); 42 USC 1382c.

“(B) with respect to whom there has been a determination by the State that—

“(i) the individual requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility,

“(ii) it is appropriate to provide such care for the individual outside such an institution, and

“(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

“(C) if the individual were in a medical institution, would be eligible to have a supplemental security income (or State supplemental) payment made with respect to him under title XVI, shall be deemed, for purposes of this title only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under title XVI.” 42 USC 1381.

(b) The amendment made by subsection (a) shall become effective on October 1, 1982. Effective date. 42 USC 1396a note.

SIX-MONTH MORATORIUM ON DEREGULATION OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 135. The Secretary of Health and Human Services may not promulgate any change in the regulations prescribed under—

(1) subpart K of part 405 of subchapter B (relating to medicare conditions of participation of skilled nursing facilities),

(2) so much of subpart S of part 405 of subchapter B (relating to certification procedure for providers) as relates to certification of skilled nursing facilities, and

(3) subparts C, D, and E of part 442 of subchapter C (relating to medicaid certification and requirements for skilled nursing and intermediate care facilities), of chapter IV of title 42 of the Code of Federal Regulations until the first day of the seventh calendar month beginning after the date of the enactment of this Act unless ordered to do so by a court of competent jurisdiction.

MEDICAID PROGRAM IN AMERICAN SAMOA

SEC. 136. (a) Section 1101(a)(1) of the Social Security Act is amended by inserting “and American Samoa” after “Such term when used in title XIX also includes the Northern Mariana Islands”. 42 USC 1301.

(b) Section 1108(c) of such Act is amended— 42 USC 1308.

(1) by striking out “and” at the end of paragraph (3);

(2) by striking out the period at the end of paragraph (4) and inserting in lieu thereof “, and”; and

(3) by adding at the end thereof the following:

“(5) American Samoa shall not exceed \$750,000.”.

42 USC 1396d.

(c) Section 1905(b)(2) of such Act is amended by striking out “and the Northern Mariana Islands” and inserting in lieu thereof “the Northern Mariana Islands, and American Samoa”.

42 USC 1396a.

(d) Section 1902 of such Act (as amended by section 132(c) of this Act) is amended by adding at the end thereof the following new subsection:

“(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa for care and services described in paragraphs (1) through (18) of section 1905(a).”.

42 USC 1308.

42 USC 1396d.

Effective date.

42 USC 1301

note.

(e) The amendments made by this section shall become effective on October 1, 1982.

TECHNICAL CORRECTIONS FROM OMNIBUS BUDGET RECONCILIATION ACT OF 1981

95 Stat. 803.

42 USC 1396b.

SEC. 137. (a)(1) Section 2161(b) of the Omnibus Budget Reconciliation Act of 1981 is amended by striking out “Section 1902” and inserting in lieu thereof “Section 1903”.

(2) Paragraphs (1) and (2) of section 2161(c) of such Act are each amended by striking out “section 1902” and inserting in lieu thereof in each instance “section 1903”.

95 Stat. 807.

42 USC 1396a.

(3) Section 2171(a)(3) of such Act is amended by striking out “by striking out paragraph (C)” and inserting in lieu thereof “by striking out ‘(C) if medical assistance’ and all that follows through the semicolon preceding ‘except that’”.

95 Stat. 815.

42 USC 603 note.

42 USC 1396.

(4) Section 2181(b) of such Act is amended by inserting before the period at the end thereof the following: “, except that, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order to incorporate the provisions required to be included by this section into such State plan, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to include the provisions required to be included in such State plan by subsection (a)(2) of this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act, but the requirements previously set forth in paragraphs (1) through (3) of section 403(g) of the Social Security Act (prior to its repeal by this section) shall apply under title XIX of such Act to such State on and after October 1, 1981, whether or not the provisions required to be included by this section in the State plan under title XIX have been incorporated into such State plan”.

42 USC 603.

(5) Section 2193(c)(3)(B) of such Act is amended by striking out “or X” and inserting in lieu thereof “or XIX”.

95 Stat. 826.

42 USC 1320a-1.

95 Stat. 819.

42 USC 701.

(b)(1) Section 501(b)(1)(D) of the Social Security Act is amended by striking out “title IV” and inserting in lieu thereof “title VI”.

(2) Section 501(b)(2) of such Act is amended by striking out “section 624 of the Economic Opportunity Act of 1964” and inserting in lieu thereof “section 673(2) of the Omnibus Budget Reconciliation Act of 1981”.

- (3) Section 505(2)(B) of such Act is amended by striking out "502(b)(1)" and inserting in lieu thereof "501(b)(1)". 95 Stat. 822.
42 USC 705.
- (4) Section 505(2)(D) of such Act is amended by striking out "the State imposes any charges" and inserting in lieu thereof "any charges are imposed".
- (5) Section 1134(4) of such Act is amended by striking out "scale" and inserting in lieu thereof "sale". 42 USC 1320b-4.
- (6) The heading of title XVI of such Act as such title applies in the case of Puerto Rico, Guam, and the Virgin Islands is amended by striking out ", OR FOR SUCH AID FOR THE AGED". 42 USC 1381.
- (7) Section 1902(a)(10)(A) of such Act is amended to read as follows: 95 Stat. 807.
42 USC 1396a.
- "(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—
- "(i) all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI; and 42 USC 1396d.
- "(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but— 42 USC 1396d.
- "(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),
- "(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,
- "(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,
- "(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplementary payment;
- "(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C), or 42 USC 1396b.
- "(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination

that but for the provision of home or community-based services described in section 1915(c) they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1915(c);”.

(8) Section 1902(a)(10)(C)(i) of such Act is amended—

(A) by striking out “and (II)” and inserting in lieu thereof “, (II)”; and

(B) by inserting before the semicolon at the end thereof “, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups”.

(9) Section 1902(a)(10)(C)(ii)(I) of such Act is amended by striking out “described in section 1905(a)(i)” and inserting in lieu thereof “under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i)”.

(10) Section 1902(b) of such Act is amended by striking out paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(11) Section 1903(g)(1) of such Act is amended by inserting “or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)” after “as defined in section 1876”.

(12) Section 1903(g)(1)(A) of such Act is amended by striking out “intermediate care facility services described in section 1905(d)” and inserting in lieu thereof “intermediate care facility services provided in an institution for the mentally retarded”.

(13) Section 1903(k) of such Act is amended by striking out “section 1876” and inserting in lieu thereof “subsection (m) of this section”.

(14) Section 1903(m)(2)(A) of such Act is amended—

(A) by striking out “and” before “(II)” in clause (iv) and inserting in lieu thereof “or”; and

(B) by striking out “unforeseen” in clause (vii) and inserting in lieu thereof “unforeseen”.

(15) Section 1903(s) of such Act is amended—

(A) in paragraph (1)(A), by striking out “made before fiscal year 1981” and inserting in lieu thereof “made before fiscal year 1982”;.

(B) in paragraph (1)(A), by striking out “without regard to payments under subsection (t) and” and inserting in lieu thereof “without regard to payments under subsections (a)(6) and (t), without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service, and”;

95 Stat. 809.
42 USC 1396a.

95 Stat. 807.
42 USC 1396a.

95 Stat. 807.
42 USC 1396a.

42 USC 1396a.

42 USC 1396b.

95 Stat. 816.
42 USC 1396b.

95 Stat. 813.
42 USC 1396b.

95 Stat. 803.
42 USC 1396b.

(C) in paragraph (1)(C), by inserting "a program in operation under" before "a plan approved under this title";

(D) in paragraph (3)(D)—

(i) by striking out "determines that" and inserting in lieu thereof "must determine that";

(ii) by striking out "most recent calendar year" and inserting in lieu thereof "most recent year (which shall consist of a 12-month period determined by the Secretary for this purpose)";

(iii) by striking out "2 or 3 calendar year period" and inserting in lieu thereof "2- or 3-year period"; and

(iv) by striking out "calendar" each place it appears;

(E) in paragraph (4)(B), by inserting "and paragraph (3)(D)" after "subparagraph (A)"; and

(F) in paragraph (5)(A)(i), by inserting "(including amounts saved, to the extent such amounts can be documented to the satisfaction of the Secretary, by reason of the suspension or termination of a provider or other person for fraud or abuse, but only during the period of such suspension or termination or, if shorter, the 1-year period beginning on the date of such termination or suspension)" after "recovered or diverted".

(16) Section 1903(t) of such Act (as added by section 2161(b) of the Omnibus Budget Reconciliation Act of 1981 as amended by subsection (a) of this section) is amended—

95 Stat. 805.
42 USC 1396b.

(A) in paragraphs (1)(A) and (2)(A), by striking out "other than interest paid under subsection (d)(5)" each place it appears and inserting in lieu thereof in each instance "other than payments under subsection (a)(6), interest paid under subsection (d)(5), and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service";

(B) in paragraph (1)(B), by striking out "between September 1982 and September 1983" and inserting in lieu thereof "for the 12-month period ending on September 30, 1983";

(C) in paragraph (1)(C), by striking out "between September 1982 and September 1984" and inserting in lieu thereof "for the 24-month period ending on September 30, 1984";

(D) in subparagraphs (B) and (C) of paragraph (1), by striking out "consumer price index for all urban consumers (published by the Bureau of Labor Statistics)" each place it appears and inserting in lieu thereof in each instance "Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics"; and

(E) by amending paragraph (3) to read as follows:

"(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal years 1982, 1983, and 1984 (in the case of the payment which may be made for the first quarter of fiscal years 1983, 1984, and 1985, respectively), the Federal medical assistance percentage for fiscal years 1982, 1983, and 1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1981, disregarding any change in such percentage after fiscal year 1981."

(17) Section 1905(a)(i) of such Act is amended by striking out "or any reasonable category of such individuals,".

95 Stat. 808.
42 USC 1396d.

(18) Section 1905(a) of such Act is amended by striking out "or" at the end of clause (vi), inserting "or" at the end of clause (vii), and inserting after clause (vii) the following:

“(viii) pregnant women.”

95 Stat. 809.
42 USC 1396n.

(19)(A) Section 1915(b) of such Act is amended by striking out “and section 1903(m)”.

42 USC 1396n
note.

(B) The amendment made by subparagraph (A) shall not apply with respect to any waiver if such waiver was granted, and the arrangement covered by the waiver was in place, prior to August 10, 1982.

(20) Section 1915(b)(1) of such Act is amended—

(A) by inserting “primary care” before “case-management system”; and

(B) by striking out “primary care services” and inserting in lieu thereof “medical care services”.

(21) Section 1915(c)(1) of such Act is amended by inserting “payment for part or all of the cost of” after “may include as ‘medical assistance’ under such plan”.

(22) Section 1915(c)(2)(B) of such Act is amended to read as follows:

“(B) the State will provide, with respect to individuals who—

“(i) are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan,

“(ii) may require such services, and

“(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for such services;”.

(23) Section 1915(c)(3) of such Act is amended—

(A) by striking out “subsection (a)(1)” and inserting in lieu thereof “section 1902(a)(1)”; and

(B) by striking out “subsection (a)(10) of section 1902” and inserting in lieu thereof “section 1902(a)(10)”.

(24) Section 1915(c)(4) of such Act is amended by striking out “this section” and inserting in lieu thereof “this subsection”.

(25) Section 1915(f) of such Act is amended by inserting “approval of” before “a proposed State plan”.

95 Stat. 789.
42 USC 1320a-7a.

(26) Subsection (a) of section 1128A of such Act is amended by striking out all that precedes “shall be subject” and inserting in lieu thereof the following:

“(a) Any person (including an organization, agency, or other entity) that—

“(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines is for a medical or other item or service—

“(A) that the person knows or has reason to know was not provided as claimed, or

“(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or

“(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency not to charge a person for an item or service in excess of the amount permitted to be charged,”.

42 USC 1320a-7,
1320c-9, 1320c-
11.
42 USC 1320c-15.

42 USC 1395u.

(27) Section 1903(s)(5)(B) of such Act is amended by inserting “or quarters” after “carried forward to the following quarter”.

95 Stat. 803.
42 USC 1396b.

(c)(1) Section 914(b)(2)(A) of the Omnibus Reconciliation Act of 1980 is amended by striking out “medical assistance” and all that follows and inserting in lieu thereof “cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title XIX of the Social Security Act.”.

42 USC 1396a
note.

(2) Section 914(c)(2) of the Omnibus Reconciliation Act of 1980 is amended by striking out “services provided” and all that follows and inserting in lieu thereof “cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title V of the Social Security Act.”.

42 USC 1396.
42 USC 705 note.

(d)(1) Except as otherwise provided in this section, any amendment to the Omnibus Budget Reconciliation Act of 1981 made by this section shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

42 USC 701.
42 USC 1396a
note.
95 Stat. 357.

(2) Except as otherwise provided in this section, any amendment to the Social Security Act made by the preceding provisions of this section shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of the Social Security Act was amended by the Omnibus Budget Reconciliation Act of 1981.

42 USC 301 note.

(e) Section 1902(a) of the Social Security Act is amended in the matter following paragraph (44) by inserting “, (26)” after “(9)(A)”.

95 Stat. 815.
42 USC 1396a.

(f) Section 1905(h)(1)(C) of the Social Security Act is amended by redesignating clauses (i) and (ii) as subclauses (I) and (II) respectively, and by redesignating clauses (A) and (B) as clauses (i) and (ii) respectively.

42 USC 1396d.

(g) Effective October 1, 1982, section 1903(f)(3) of the Social Security Act is amended by striking out “(without regard to section 408)”.

42 USC 1396b.

Subtitle C—Utilization and Quality Control Peer Review

Peer Review
Improvement
Act of 1982.

SHORT TITLE OF SUBTITLE

SEC. 141. This subtitle may be cited as the “Peer Review Improvement Act of 1982”.

42 USC 1305
note.

REQUIREMENT FOR SECRETARY TO ENTER INTO CONTRACTS

SEC. 142. Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 1395y.

“(g) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this title, enter into contracts with utilization and quality control peer review organizations pursuant to part B of title XI of this Act.”.

42 USC 1320c.

ESTABLISHMENT OF UTILIZATION AND QUALITY CONTROL PEER REVIEW
PROGRAM

SEC. 143. Part B of title XI of the Social Security Act is amended to read as follows:

**“PART B—PEER REVIEW OF THE UTILIZATION AND
QUALITY OF HEALTH CARE SERVICES****“PURPOSE**

42 USC 1320c.

“SEC. 1151. The purpose of this part is to establish the contracting process which the Secretary must follow pursuant to the requirements of section 1862(g) of this Act, including the definition of the utilization and quality control peer review organizations with which the Secretary shall contract, the functions such peer review organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part.

42 USC 1395y.

**“DEFINITION OF UTILIZATION AND QUALITY CONTROL PEER REVIEW
ORGANIZATION**

42 USC 1320c-1

“SEC. 1152. The term ‘utilization and quality control peer review organization’ means an entity which—

“(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1153, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured; and

“(2) is able, in the judgment of the Secretary, to perform review functions required under section 1154 in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice.

**“CONTRACTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW
ORGANIZATIONS**

42 USC 1320c-2.

“SEC. 1153. (a)(1) The Secretary shall establish throughout the United States geographic areas with respect to which contracts under this part will be made. In establishing such areas, the Secretary shall use the same areas as established under section 1152 of this Act as in effect immediately prior to the date of the enactment of the Peer Review Improvement Act of 1982, but subject to the provisions of paragraph (2).

“(2) As soon as practicable after the date of the enactment of the Peer Review Improvement Act of 1982, the Secretary shall consoli-

date such geographic areas, taking into account the following criteria:

“(A) Each State shall generally be designated as a geographic area for purposes of paragraph (1).

“(B) The Secretary shall establish local or regional areas rather than State areas only where the volume of review activity or other relevant factors (as determined by the Secretary) warrant such an establishment, and the Secretary determines that review activity can be carried out with equal or greater efficiency by establishing such local or regional areas. In applying this subparagraph the Secretary shall take into account the number of hospital admissions within each State for which payment may be made under title XVIII or a State plan approved under title XIX, with any State having fewer than 180,000 such admissions annually being established as a single statewide area, and no local or regional area being established which has fewer than 60,000 total hospital admissions (including public and private pay patients) under review annually, unless the Secretary determines that other relevant factors warrant otherwise.

42 USC 1391.

42 USC 1396.

“(C) No local or regional area shall be designated which is not a self-contained medical service area, having a full spectrum of services, including medical specialists' services.

“(b)(1) The Secretary shall enter into a contract with a utilization and quality control peer review organization for each area established under subsection (a) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part. If more than one such qualified organization meets the requirements of the preceding sentence, priority shall be given to any such organization which is described in section 1152(1)(A).

“(2)(A) During the first twelve months in which the Secretary is entering into contracts under this section, the Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), an entity which directly or indirectly makes payments to any practitioner or provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this part.

“(B) If, after the expiration of the twelve-month period referred to in subparagraph (A), the Secretary determines that there is no other entity available for an area with which the Secretary can enter into a contract under this part, the Secretary may then enter into a contract under this part with an entity described in subparagraph (A) for such area if such entity otherwise meets the requirements of this part.

“(3) The Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part.

“(c) Each contract with an organization under this section shall provide that—

"(1) the organization shall perform the functions set forth in section 1154(a), or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b), a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

"(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

"(3) the contract shall be for an initial term of two years and shall be renewable on a biennial basis thereafter;

"(4) if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

"(5) the organization may terminate the contract upon 90 days notice to the Secretary;

"(6) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

"(A) the organization does not substantially meet the requirements of section 1152; or

"(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under subsection (d);

"(7) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

"(8) reimbursement shall be made to the organization in accordance with the terms of the contract.

"(d)(1) Prior to making any termination under subsection (c)(5)(B), the Secretary must provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract. Such data and other information shall be reviewed in a timely manner by a panel appointed by the Secretary, and the panel shall submit a report of its findings to the Secretary in a timely manner. The Secretary shall make a copy of the report available to the organization.

"(2) The Secretary may accept or not accept the findings of the panel. After the panel has submitted a report with respect to an organization, the Secretary may, with the concurrence of the organization, amend the contract to modify the scope of the functions to be carried out by the organization, or in any other manner. The Secretary may terminate a contract under the authority of subsection (c)(5)(C) upon 90 days notice after the panel has submitted a report, or earlier if the organization so agrees.

"(3) A panel appointed by the Secretary under this subsection shall consist of not more than five individuals, each of whom shall be a member of a utilization and quality control peer review organization having a contract with the Secretary under this part. While

serving on such panel individuals shall be paid at a per diem rate not to exceed the current per diem equivalent at the time that service on the panel is rendered for grade GS-18 under section 5332 of title 5, United States Code. Appointments shall be made without regard to title 5, United States Code.

“(e) Contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

“(f) Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

“FUNCTIONS OF PEER REVIEW ORGANIZATIONS

“SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions: 42 USC 1320c-3.

“(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract, of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under title XVIII for the purpose of determining whether— 42 USC 1395.

“(A) such services and items are or were reasonable and medically necessary or otherwise allowable under section 1862(a)(1);

“(B) the quality of such services meets professionally recognized standards of health care; and

“(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.

“(2) The organization shall determine, on the basis of the review carried out under subparagraphs (A) and (C) of paragraph (1), whether payment shall be made for services under title XVIII. Such determination shall constitute the conclusive determination on those issues for purposes of payment under title XVIII, except that payment may be made if—

“(A) such payment is allowed by reason of section 1879;

“(B) in the case of inpatient hospital services or posthospital extended care services, the peer review organization determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this subparagraph for not more than two days, but only in the case where the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under title XVIII prior to notification by the organization under paragraph (3); 42 USC 1395pp.

“(C) such determination is changed as the result of any hearing or review of the determination under section 1155; or

42 USC 1395x.

“(D) such payment is authorized under section 1861(v)(1)(G).

“(3) Whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such practitioner or provider, such patient, and the agency or organization responsible for the payment of claims under title XVIII of this Act. In the case of practitioners and providers of services, the organization shall provide an opportunity for discussion and review of the determination.

“(4) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations.

“(5) The organization shall consult with nurses and other professional health care practitioners (other than physicians described in section 1861(r)(1)) and with representatives of institutional and noninstitutional providers of health care services, with respect to the organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

“(6) The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate. Such norms with respect to treatment for particular illnesses or health conditions shall include—

“(A) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care, are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care; and

“(B) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

“(7) The organization, to the extent necessary and appropriate to the performance of the contract, shall—

“(A) make arrangements to utilize the services of persons who are practitioners of, or specialists in, the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

“(B) undertake such professional inquiries either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review which in the judgment of such organization will facilitate its activities;

“(C) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1); and

“(D) inspect the facilities in which care is rendered or services are provided (which are located in such area) of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1).

“(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part.

“(9) The organization shall collect such information relevant to its functions, and keep and maintain such records, in such form as the Secretary may require to carry out the purposes of this part, and shall permit access to and use of any such information and records as the Secretary may require for such purposes, subject to the provisions of section 1160.

Post, p. 391.

“(10) The organization shall coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations including—

“(A) agencies under contract pursuant to sections 1816 and 1842 of this Act;

42 USC 1395h,
1395u.

“(B) other peer review organizations having contracts under this part; and

“(C) other public or private review organizations as may be appropriate.

“(11) The organization shall make available its facilities and resources for contracting with private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities.

“(b)(1) No physician shall be permitted to review—

“(A) health care services provided to a patient if he was directly responsible for providing such services; or

“(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

“(2) For purposes of this subsection, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

“(c) No utilization and quality control peer review organization shall utilize the services of any individual who is not a duly licensed doctor of medicine, osteopathy, or dentistry to make final determinations of denial decisions in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine, osteopathy, or dentistry, or

any act performed by any duly licensed doctor of medicine, osteopathy, or dentistry in the exercise of his profession.

“RIGHT TO HEARING AND JUDICIAL REVIEW

42 USC 1320c-4.
42 USC 1395.

“SEC. 1155. Any beneficiary who is entitled to benefits under title XVIII, and any practitioner or provider, who is dissatisfied with a determination made by a contracting peer review organization in conducting its review responsibilities under this part, shall be entitled to a reconsideration of such determination by the reviewing organization. Where the reconsideration is adverse to the beneficiary and where the matter in controversy is \$200 or more, such beneficiary shall be entitled to a hearing by the Secretary (to the same extent as is provided in section 205(b)), and, where the amount in controversy is \$2,000 or more, to judicial review of the Secretary's final decision.

42 USC 405.

“OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

42 USC 1320c-5.

“SEC. 1156. (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under title XVIII, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under such title—

“(1) will be provided economically and only when, and to the extent, medically necessary;

“(2) will be of a quality which meets professionally recognized standards of health care; and

“(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

“(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

“(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

“(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under title XVIII, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide such services on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120

days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

“(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective at such time and upon such reasonable notice to the public and to the practitioner or person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in title XVIII with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

“(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

“(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

42 USC 405.

“(c) It shall be the duty of each utilization and quality control peer review organization to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or person (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

“LIMITATION ON LIABILITY

“SEC. 1157. (a) Notwithstanding any other provision of law, no person providing information to any organization having a contract with the Secretary under this part shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

42 USC 1320c-6.

“(1) such information is unrelated to the performance of the contract of such organization; or

"(2) such information is false and the person providing it knew, or had reason to believe, that such information was false.

"(b) No person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance by him of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

"(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract pursuant to section 1153 operating in the area where such doctor of medicine or osteopathy or provider took such action; but only if—

"(1) he takes such action in the exercise of his profession as a doctor of medicine or osteopathy or in the exercise of his functions as a provider of health care services; and

"(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

"(d) The Secretary shall make payment to an organization under contract with him pursuant to this part, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function under such contract by such organization, member, or employee.

**"APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING
FEDERAL FINANCIAL ASSISTANCE**

"SEC. 1158. (a) A State plan approved under title XIX of this Act may provide that the functions specified in section 1154 may be performed in an area by contract with a utilization and quality control peer review organization that has entered into a contract with the Secretary in accordance with the provisions of section 1862(g).

"(b) In the event a State enters into a contract in accordance with subsection (a), the Federal share of the expenditures made to the contracting organization for its costs in the performance of its functions under the State plan shall be 75 percent (as provided in section 1903(a)(3)(C)).

**"AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE
PROVISIONS OF THIS PART**

"SEC. 1159. Expenses incurred in the administration of the contracts described in section 1862(g) shall be payable from—

"(1) funds in the Federal Hospital Insurance Trust Fund; and

“(2) funds in the Federal Supplementary Medical Insurance Trust Fund,

in such amounts from each of such Trust Funds as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to each of such programs. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between them in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

“PROHIBITION AGAINST DISCLOSURE OF INFORMATION

“SEC. 1160. (a) An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except—

42 USC 1320c-9.

“(1) to the extent that may be necessary to carry out the purposes of this part,

“(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

“(3) in accordance with subsection (b).

“(b) An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information—

“(1) which may identify specific providers or practitioners as may be necessary—

“(A) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case or pattern;

“(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the peer review organization to any such agency—

“(i) at the discretion of the peer review organization, at the request of such agency relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

“(ii) upon a finding by, or the reasonable belief of, the peer review organization that there may be a substantial risk to the public health; and

“(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case, but only to the extent that such data and

information is required by the agency in carrying out a function which is within the jurisdiction of such agency under State law; and

“(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such organization, and shall be in the form of aggregate statistical data (without explicitly identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

“(c) It shall be unlawful for any person to disclose any such information described in subsection (a) other than for the purposes provided in subsections (a) and (b), and any person violating the provisions of this section shall, upon conviction, be fined not more than \$1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

“(d) No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpoena or discovery proceedings in a civil action.

“ANNUAL REPORTS

42 USC 1320c-10.

“SEC. 1161. The Secretary shall submit to the Congress not later than April 1 of each year, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

“(1) the number, status, and service areas of all utilization and quality control peer review organizations participating in the program;

“(2) the number of health care institutions and practitioners whose services are subject to review by such organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

“(3) the various methods of reimbursement utilized in contracts under this part, and the relative efficiency of each such method of reimbursement;

“(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

“(5) the total costs incurred under titles XVIII and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality; and

42 USC 1395,
1396.

“(6) descriptions of the criteria upon which decisions are made, and the selection and relative weights of such criteria.

“EXEMPTIONS OF CHRISTIAN SCIENCE SANATORIUMS

“SEC. 1162. The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

42 USC 1320c-11.

“MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

“SEC. 1163. For purposes of applying this part to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.”.

42 USC 1320c-12.

FACILITATION OF PRIVATE REVIEW

SEC. 144. Section 1866(a)(1) of the Social Security Act is amended—

42 USC 1395cc.

(1) by striking out “and” at the end of subparagraphs (A), (B), and (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof “, and”; and

(3) by inserting after subparagraph (D) the following new subparagraph:

“(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes.”.

42 USC 1301.

WAIVER OF LIABILITY PROVISION

SEC. 145. Section 1879(a) of the Social Security Act is amended by adding at the end thereof the following new sentence: “Any provider or other person furnishing items or services for which payment may not be made by reason of section 1862(a)(1) or (9) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a utilization and quality control peer review organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.”.

42 USC 1395pp.

42 USC 1395y.

MEDICAID PROVISIONS

95 Stat. 795.
42 USC 1396a.

SEC. 146. (a) Section 1902(d) of the Social Security Act is amended—

(1) by striking out “a Professional Standards Review Organization designated, conditionally or otherwise,” and inserting in lieu thereof “a utilization and quality control peer review organization having a contract with the Secretary”; and

(2) by striking out “such Organization (or Organizations)” each place it appears and inserting in lieu thereof in each instance “such organization (or organizations)”.

95 Stat. 795.
42 USC 1396b.

(b) Section 1903(a)(3)(C) of such Act is amended by striking out “Professional Standards Review Organization” and inserting in lieu thereof “utilization and quality control peer review organization”.

DEMONSTRATION PROJECTS FOR COMPETITIVE BIDDING AND OTHER
REIMBURSEMENT METHODS

42 USC 1395b-1.

SEC. 147. Section 402(a)(1) of the Social Security Amendments of 1967 (Public Law 90-248) is amended—

(1) by striking out “and” at the end of subparagraph (I);

(2) by striking out the period at the end of subparagraph (J) and inserting in lieu thereof “; and”; and

(3) by inserting after subparagraph (J) the following new subparagraph:

“(K) to determine whether the use of competitive bidding in the awarding of contracts, or the use of other methods of reimbursement, under part B of title XI would be efficient and effective methods of furthering the purposes of that part.”.

TECHNICAL AMENDMENTS

42 USC 1395y.

SEC. 148. (a) Section 1862(d)(1)(C) of such Act is amended by striking out “, on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title),” and inserting in lieu thereof “on the basis of information acquired by the Secretary in the administration of this title”.

42 USC 1395g,
1395x.

(b) Sections 1815(b), 1861(v)(1)(G), and 1861(w)(2) of such Act are each amended by striking out “Professional Standards Review Organization” and inserting in lieu thereof in each instance “quality control and peer review organization”.

42 USC 1395k.

(c) Section 1832(a)(2)(F)(ii) of such Act is amended by striking out “Professional Standards Review Organization (designated, conditionally or otherwise,” and inserting in lieu thereof “quality control and peer review organization (having a contract with the Secretary”.

42 USC 1395l.

(d) Section 1833(i) of such Act is amended by striking out “the National Professional Standards Review Council and”.

42 USC 1395pp.

(e) Section 1879(e) of such Act is amended by striking out “professional standards review organization” and inserting in lieu thereof “quality control and peer review organization”.

EFFECTIVE DATE

SEC. 149. The amendments made by this part shall, subject to section 150, be effective with respect to contracts entered into or renewed on or after the date of the enactment of this Act.

42 USC 1320c
note.

MAINTENANCE OF CURRENT PSRO AGREEMENTS

SEC. 150. (a) The Secretary of Health and Human Services shall not terminate or fail to renew any agreement in effect with a professional standards review organization under part B of title XI of the Social Security Act on the earlier of the date of the enactment of this Act or September 30, 1982 until such time as he enters into a contract with a utilization and quality control peer review organization under such part, as amended by this subtitle, for the area served by such professional standards review organization. In complying with this subsection, the Secretary may renew any such contract with a professional standards review organization for a period of less than 12 months.

42 USC 1320c
note.

42 USC 1301.

(b) The provisions of part B of title XI of the Social Security Act as in effect prior to the amendments made by this subtitle shall remain in effect with respect to contracts with professional standards review organizations in effect on the earlier of the date of the enactment of this Act or September 30, 1982, until such time as such contract is terminated or is not renewed, in accordance with subsection (a). Any matters awaiting a determination by a Statewide Professional Standards Review Council on the date of the enactment of this Act shall be transferred to the Secretary of Health and Human Services for a determination unless such determination is made by such Council within 30 days after the date of the enactment of this Act. No payments shall be made under part B of title XI of the Social Security Act to Statewide Professional Standards Review Councils for services performed under section 1162 of such Act after the end of such 30-day period.

42 USC 1301.

42 USC 1301.

42 USC 1320c-11.

Subtitle D—Aid to Families with Dependent Children

ROUNDING OF ELIGIBILITY AND BENEFIT AMOUNTS

SEC. 151. (a) Section 402(a) of the Social Security Act is amended—

95 Stat. 857.
42 USC 602.

(1) by striking out “and” at the end of paragraph (32);

(2) by striking out the period at the end of paragraph (33) and inserting in lieu thereof “; and”; and

(3) by adding at the end thereof the following new paragraph:

“(34) provide that both the standard of need applied to a family and the amount of aid determined to be payable, when not a whole dollar amount, shall be rounded to the next lower whole dollar amount.”.

(b) The amendment made by this section shall become effective on October 1, 1982.

Effective date.
42 USC 602 note.

EFFECTIVE DATE OF APPLICATION; PRORATION OF FIRST-MONTH'S AFDC
BENEFIT

42 USC 602.

SEC. 152. (a) Section 402(a)(10) of the Social Security Act is amended—

(1) by striking out “provide, effective July 1, 1951, that all individuals” and inserting in lieu thereof “(A) provide that all individuals”;

(2) by adding “and” after the semicolon; and

(3) by adding at the end thereof the following new subparagraph:

“(B) provide that an application for aid under the plan will be effective no earlier than the date such application is filed with the State agency or local agency responsible for the administration of the State plan, and the amount payable for the month in which the application becomes effective, if such application becomes effective after the first day of such month, shall bear the same ratio to the amount which would be payable if the application had been effective on the first day of such month as the number of days in the month including and following the effective date of the application bears to the total number of days in such month;”.

42 USC 602 note.

(b) The amendments made by this section shall become effective on October 1, 1982.

ABSENCE FROM HOME SOLELY BY REASON OF UNIFORMED SERVICE

42 USC 606.

SEC. 153. (a) Section 406(a)(1) of the Social Security Act is amended by inserting “(other than absence occasioned solely by reason of the performance of active duty in the uniformed services of the United States)” after “continued absence from the home”.

Effective date.

42 USC 606 note.

(b) The amendment made by this section shall become effective on October 1, 1982.

JOB SEARCH

42 USC 602.

SEC. 154. (a) Section 402(a) of the Social Security Act (as amended by section 151(a) of this Act) is further amended—

(1) by striking out “and” at the end of paragraph (33);

(2) by striking out the period at the end of paragraph (34) and inserting in lieu thereof “; and”; and

(3) by adding at the end thereof the following new paragraph:

“(35) at the option of the State, provide—

“(A) that as a condition of eligibility for aid under the State plan of any individual claiming such aid who is required to register pursuant to paragraph (19)(A) (or who would be required to register under paragraph (19)(A) but for clause (iii) thereof, including all such individuals or only such groups, types, or classes thereof as the State agency may designate for purposes of this paragraph, such individual will be required to participate in a program of employment search—

“(i) beginning at the time he applies for such aid (or an application including his need is filed) and continuing for a period (prescribed by the State) of not more than eight weeks (but this requirement may not be used as a reason for any delay in making a determination of an individual's eligibility for aid or in issuing a

payment to or in behalf of any individual who is otherwise eligible for such aid); and

“(ii) at such time or times after the close of the period prescribed under clause (i) as the State agency may determine but not to exceed a total of 8 weeks in any 12 consecutive months;

“(B) that any individual participating in a program of employment search under this paragraph will be furnished such transportation and other services, or paid (in advance or by way of reimbursement) such amounts to cover transportation costs and other expenses reasonably incurred in meeting requirements imposed on him under this paragraph, as may be necessary to enable such individual to participate in such program; and

“(C) that, in the case of an individual who fails without good cause to comply with requirements imposed upon him under this paragraph, the sanctions imposed by paragraph (19)(F) shall be applied in the same manner as if the individual had made a refusal of the type which would cause the provisions of such paragraph (19)(F) to be applied (except that the State may at its option, for purposes of this paragraph, reduce the period for which such sanctions would otherwise be in effect).”.

(b)(1) Section 403(a)(3)(C) of such Act is amended by inserting immediately after “expenditures” the following: “(including as expenditures under this subparagraph the value of any services furnished, and the amount of any payments made (to cover expenses incurred by individuals under a program of employment search), under section 402(a)(35)(B))”. 42 USC 603.

(2) Section 403(a)(3) of such Act is further amended by striking out “other than services” in the matter immediately following subparagraph (C) and inserting in lieu thereof the following: “other than services furnished under section 402(a)(35)(B) (as described in the parenthetical phrase in subparagraph (C)), and other than services”.

(c) Section 409(b)(3) of such Act is amended—

95 Stat. 846.
42 USC 609.

(1) in the first sentence—

(A) by inserting “, any program of employment search under section 402(a)(35),” after “pursuant to this section”,

(B) by striking out “both such programs” and inserting in lieu thereof “more than one such program”, and

(C) by striking out “in the other” and inserting in lieu thereof “in another”; and

(2) in the second sentence, by striking out “both such programs” and inserting in lieu thereof “more than one such program”.

(d) The amendments made by this section shall become effective on October 1, 1982.

Effective date.
42 USC 602 note.

PRORATION OF STANDARD AMOUNT FOR SHELTER AND UTILITIES

SEC. 155. (a) Section 412 of the Social Security Act is amended to read as follows: 42 USC 612.

“PRORATING SHELTER ALLOWANCE OF AFDC FAMILY LIVING WITH
ANOTHER HOUSEHOLD

“SEC. 412. A State plan for aid and services to needy families with children may provide that, in determining the need of any dependent child or relative claiming aid who is living with other individuals (not claiming aid together with such child or relative) as a household (as defined, for purposes of this section, by the Secretary), the amount included in the standard of need, and the payment standard, applied to such child or relative for shelter, utilities, and similar needs may be prorated on a reasonable basis, in such manner and under such circumstances as the State may determine to be appropriate. For purposes of any method of proration used by a State under this section, there shall not be included as a member of a household an individual receiving benefits under title XVI in any month to whom the one-third reduction prescribed by section 1612(a)(2)(A)(i) is applied.”

(b) The amendment made by this section shall become effective on October 1, 1982.

LIMITATION ON FEDERAL FINANCIAL PARTICIPATION IN ERRONEOUS
ASSISTANCE EXPENDITURES

SEC. 156. (a) Section 403(i) of the Social Security Act is amended to read as follows:

“(i)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State’s erroneous excess payments (as defined in subparagraph (C)) to its total payments under the State plan approved under this part exceeds—

“(i) 0.04 for fiscal year 1983, or

“(ii) 0.03 for any fiscal year thereafter,

then the Secretary shall make no payment for such fiscal year with respect to so much of the erroneous excess payments (as so defined) as exceeds the allowable error rate for such fiscal year.

“(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a fiscal year despite a good faith effort by such State.

“(C) For purposes of this subsection, the term ‘erroneous excess payments’ means the total of (i) payments to ineligible families, and (ii) overpayments to eligible families.

“(2) The State agency administering the plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

“(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

“(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State’s error rate for a fiscal year, the amount that would otherwise

42 USC 1381.

42 USC 1382a.

Effective date.

42 USC 612 note.

42 USC 603.

be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

“(4) This subsection shall not apply with respect to Puerto Rico, Guam, or the Virgin Islands.”.

(b) Section 403(a) of such Act is amended by striking out “In the case of calendar quarters beginning after September 30, 1977, and prior to April 1, 1978, the amount to be paid to each State (as determined under the preceding provisions of this subsection or section 1118, as the case may be) shall be increased in accordance with the provisions of subsection (i) of this section.”. 42 USC 603.

(c) Section 403(j) of such Act is amended by striking out “If the dollar error rate of aid furnished by a State” and inserting in lieu thereof “In the case of Puerto Rico, Guam, or the Virgin Islands, if the dollar error rate of aid furnished by such State”. 42 USC 603.

(d)(1) The amendments made by subsections (a) and (b) shall become effective on October 1, 1982. Effective date.
42 USC 603 note.

(2) The inapplicability of section 403(j) of the Social Security Act to States other than Puerto Rico, Guam, and the Virgin Islands by reason of the amendment made by subsection (c) shall be effective with respect to six-month periods beginning after April 1983.

(e) The regulations currently in effect for fiscal year 1982 with respect to erroneous payments made by States under a State plan approved under part A of title IV of the Social Security Act (45 CFR 205.42) shall remain in effect with respect to erroneous payments made by States until new regulations reflecting the changes made by subsection (a) are promulgated and placed in effect. 42 USC 603 note.
42 USC 601.

EXCLUSION FROM INCOME OF CERTAIN STATE PAYMENTS

SEC. 157. (a) The last sentence of section 403(a) of the Social Security Act is amended by inserting before the period at the end thereof the following: “, but any such amount, if determined to have been paid by the State in recognition of the difference between the current or anticipated needs of a family for a month based upon actual income or other relevant circumstances for such month, and the needs of such family for such month based upon income and other relevant circumstances as retrospectively determined under section 402(a)(13)(A)(ii), shall not be considered income within the meaning of section 402(a)(13) for the purpose of determining the amount of aid in the succeeding months”. 42 USC 603.
42 USC 602.

(b) The amendment made by this section shall become effective on October 1, 1982. Effective date.
42 USC 603 note.

EXTENSION OF TIME FOR STATES TO ESTABLISH A WORK INCENTIVE DEMONSTRATION PROGRAM

SEC. 158. (a) Section 445(b)(1) of the Social Security Act is amended by striking out “Not later than sixty days following the date of the enactment of this section” and inserting in lieu thereof “Not later than June 30, 1984”. 95 Stat. 850.
42 USC 645.

(b) Section 445(b)(1)(B) of such Act is amended by inserting before the semicolon at the end thereof the following: “, but subject to waiver of such criteria as provided under section 1115”. 42 USC 1315.

(c) The amendments made by this section shall become effective on the date of the enactment of this Act. Effective date.
42 USC 645 note.

EXCLUSION FROM INCOME

42 USC 602 note.

SEC. 159. Notwithstanding any other provision of law, payments which are made, under a statutorily established State program, to meet certain needs of children receiving aid under the State's plan approved under part A of title IV of the Social Security Act, if—

42 USC 601.

(1) the payments are made to such children by the State agency administering such plan, but are made without Federal financial participation (under section 403(a) of such Act or otherwise), and

(2) the State program has been continuously in effect since before January 1, 1979, shall be excluded from the income of such children and their families for purposes of section 402(a)(17) of such Act, and for all the other purposes of such part A and of such plan, effective on the date of the enactment of this Act.

TECHNICAL AMENDMENTS TO SOCIAL SERVICES AND FOSTER CARE
PROVISIONS IN 1981 RECONCILIATION ACT

42 USC 1308.

SEC. 160. (a) Section 1108(a) of the Social Security Act is amended by adding at the end thereof (after and below paragraph (3)(F)) the following new sentence:

"Each jurisdiction specified in this subsection may use in its program under title XX any sums available to it under this subsection which are not needed to carry out the programs specified in this subsection."

95 Stat. 868.

42 USC 1397b.

(b) Section 2003(b) of such Act is amended in the matter following clause (2) by inserting "(other than Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands)" after "the population of all the States".

95 Stat. 871.

42 USC 1301.

(c) The last sentence of section 1101(a)(1) of such Act is amended by striking out "American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands" and inserting in lieu thereof "Guam, and the Northern Mariana Islands".

95 Stat. 871.

42 USC 671.

(d) Section 2353(r) of the Omnibus Budget Reconciliation Act of 1981 is amended to read as follows:

"(r) Section 471(a)(10) of such Act is amended to read as follows:

"(10) provides for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, and provides that the standards so established shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B of this title;"

Effective date.

42 USC 1301

note.

(e) The amendments made by this section shall be effective as of October 1, 1981.

DELAYED EFFECTIVE DATE IN CASES REQUIRING CONFORMING STATE
LEGISLATION

42 USC 602 note.

SEC. 161. In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation

is required in order to conform the State plan approved under part A of title IV of the Social Security Act to the requirements imposed by any amendment made by this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the end of the first session of the State legislature which begins after October 1, 1982, or which began prior to October 1, 1982, and remained in session for at least twenty-five calendar days after such date. For purposes of the preceding sentence, the term "session" means a regular, special, budget, or other session of a State legislature.

42 USC 601.

Subtitle E—Child Support Enforcement

FEE FOR SERVICES TO NON-AFDC FAMILIES

SEC. 171. (a) Section 454(6) of the Social Security Act is amended—

95 Stat. 862.

42 USC 654.

(1) in clause (A), by inserting "including, at the option of the State, support collection services for the spouse (or former spouse) with whom the absent parent's child is living (but only if a support obligation has been established with respect to such spouse)," after "with the State,";

(2) in clause (B), by striking out "services under the State plan (other than collection of support)" and inserting in lieu thereof "such services"; and

(3) by amending clause (C) to read as follows: "(C) any costs in excess of the fee so imposed may be collected—

"(i) from the parent who owes the child or spousal support obligation involved, or

"(ii) at the option of the State, from the individual to whom such services are made available, but only if such State has in effect a procedure whereby all persons in such State having authority to order child or spousal support are informed that such costs are to be collected from the individual to whom such services were made available;".

(b)(1) Section 454 of such Act is further amended—

95 Stat. 863.

42 USC 503.

(A) by adding "and" after the semicolon at the end of paragraph (18);

(B) by striking out paragraph (19); and

(C) by redesignating paragraph (20) as paragraph (19).

(2) Section 2333(c) of the Omnibus Budget Reconciliation Act of 1981 is amended by striking out "Section 453(a) of such Act is amended" and inserting in lieu thereof "Section 455(a) of such Act is amended".

95 Stat. 862.

42 USC 655.

(3) Section 303(e)(2)(A)(iii)(II) of the Social Security Act is amended by striking out "454(20)(B)(i)" and inserting in lieu thereof "454(19)(B)(i)".

(c) The amendments made by this section shall be effective on and after August 13, 1981.

42 USC 503 note.

ALLOTMENTS FROM PAY FOR CHILD AND SPOUSAL SUPPORT OWED BY MEMBERS OF THE UNIFORMED SERVICES ON ACTIVE DUTY

SEC. 172. (a) Part D of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

"ALLOTMENTS FROM PAY FOR CHILD AND SPOUSAL SUPPORT OWED BY
MEMBERS OF THE UNIFORMED SERVICES ON ACTIVE DUTY

42 USC 665.

"SEC. 465. (a)(1) In any case in which child support payments or child and spousal support payments are owed by a member of one of the uniformed services (as defined in section 101(3) of title 37, United States Code) on active duty, such member shall be required to make allotments from his pay and allowances (under chapter 13 of title 37, United States Code) as payment of such support, when he has failed to make periodic payments under a support order that meets the criteria specified in section 303(b)(1)(A) of the Consumer Credit Protection Act (15 U.S.C. 1673(b)(1)(A)) and the resulting delinquency in such payments is in a total amount equal to the support payable for two months or longer. Failure to make such payments shall be established by notice from an authorized person (as defined in subsection (b)) to the designated official in the appropriate uniformed service. Such notice (which shall in turn be given to the affected member) shall also specify the person to whom the allotment is to be payable. The amount of the allotment shall be the amount necessary to comply with the order (which, if the order so provides, may include arrearages as well as amounts for current support), except that the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of his pay from the uniformed service, shall not exceed the limits prescribed in sections 303 (b) and (c) of the Consumer Credit Protection Act (15 U.S.C. 1673 (b) and (c)). An allotment under this subsection shall be adjusted or discontinued upon notice from the authorized person.

"(2) Notwithstanding the preceding provisions of this subsection, no action shall be taken to require an allotment from the pay and allowances of any member of one of the uniformed services under such provisions (A) until such member has had a consultation with a judge advocate of the service involved (as defined in section 801(13) of title 10, United States Code), or with a law specialist (as defined in section 801(11) of such title) in the case of the Coast Guard, or with a legal officer designated by the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in any other case, in person, to discuss the legal and other factors involved with respect to the member's support obligation and his failure to make payments thereon, or (B) until 30 days have elapsed after the notice described in the second sentence of paragraph (1) is given to the affected member in any case where it has not been possible, despite continuing good faith efforts, to arrange such a consultation.

"(b) For purposes of this section the term 'authorized person' with respect to any member of the uniformed services means—

"(1) any agent or attorney of a State having in effect a plan approved under this part who has the duty or authority under such plan to seek to recover any amounts owed by such member as child or child and spousal support (including, when authorized under the State plan, any official of a political subdivision); and

"(2) the court which has authority to issue an order against such member for the support and maintenance of a child, or any agent of such court.

"(c) The Secretary of Defense, in the case of the Army, Navy, Air Force, and Marine Corps, and the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in the case of each of

"Authorized
person."

the other uniformed services, shall each issue regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such Secretary to implement this section.”.

(b) The amendment made by subsection (a) shall become effective on October 1, 1982.

Effective date.
42 USC 665 note.

REIMBURSEMENT OF STATE AGENCY IN INITIAL MONTH OF INELIGIBILITY FOR AFDC

SEC. 173. (a) Section 454(5) of the Social Security Act is amended by inserting “following the first month” after “for any month”.

42 USC 654.

(b) The amendment made by this section shall become effective on October 1, 1982.

Effective date.
42 USC 654 note.

REDUCTION IN CERTAIN FEDERAL PAYMENTS TO STATES UNDER CHILD SUPPORT ENFORCEMENT PROGRAM

SEC. 174. (a) Section 455(a)(1) of the Social Security Act is amended by striking out “75 percent” and inserting in lieu thereof “70 percent”.

42 USC 655.

(b) Section 455(c) of such Act is repealed.

(c) Section 458(a) of such Act is amended by striking out “15 per centum” and inserting in lieu thereof “12 percent”.

42 USC 658.

(d) The amendment made by subsection (a) shall apply with respect to quarters beginning on or after October 1, 1982. Subsection (b) shall apply with respect to quarters beginning on or after October 1, 1983; and the amendment made by subsection (c) shall apply with respect to amounts collected on or after October 1, 1983.

42 USC 655 note.

TECHNICAL AMENDMENTS TO CHILD SUPPORT ENFORCEMENT PROVISIONS IN RECONCILIATION ACT

SEC. 175. (a)(1) The first sentence of section 452(b) of the Social Security Act is amended by striking out “certify” and all that follows and inserting in lieu thereof “certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954 the amount of any child support obligation (including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A) which is assigned to such State or is undertaken to be collected by such State pursuant to section 454(6).”

42 USC 652.

26 USC 6305.

(2) Section 303(e)(2)(A)(i) of such Act is amended by striking out “of this subsection” and inserting in lieu thereof “of paragraph (1)”.

42 USC 654.

95 Stat. 863.

42 USC 503.

(b) The amendments made by this section shall be effective as of October 1, 1981.

Effective date.
42 USC 503 note.

DELAYED EFFECTIVE DATE IN CASES REQUIRING STATE LEGISLATION

SEC. 176. In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act to the requirements imposed by any amendment made by this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such part

42 USC 654 note.

42 USC 601.

"Session."

solely by reason of its failure to meet the requirements imposed by such amendment prior to the end of the first session of the State legislature which begins after October 1, 1982, or which began prior to October 1, 1982, and remained in session for at least twenty-five calendar days after such date. For purposes of the preceding sentence, the term "session" means a regular, special, budget, or other session of a State legislature.

Subtitle F—Supplemental Security Income

EFFECTIVE DATE OF APPLICATION; PRORATION OF INITIAL SSI BENEFIT PAYMENT

95 Stat. 865.
42 USC 1382.

SEC. 181. (a) Section 1611(c) of the Social Security Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following new paragraphs:

"(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Secretary so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Secretary so determines, for such month and the following month) shall—

"(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

"(B) in the case of the month in which an application becomes effective or the first month following a period of ineligibility, if such application becomes effective, or eligibility is restored, after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if such application had become effective, or eligibility had been restored, on the first day of such month as the number of days in such month including and following the effective date of such application or restoration of eligibility bears to the total number of days in such month.

"(3) For purposes of this subsection, an application of an individual for benefits under this title shall be effective on the later of—

"(A) the date such application is filed, or

"(B) the date such individual first becomes eligible for such benefits with respect to such application."

(b) The amendment made by this section shall become effective on October 1, 1982.

Effective date.
42 USC 1382
note.

ROUNDING OF SSI ELIGIBILITY AND BENEFIT AMOUNTS

42 USC 1382f.

SEC. 182. (a) Section 1617 of the Social Security Act is amended to read as follows:

"COST-OF-LIVING ADJUSTMENTS IN BENEFITS

42 USC 401.

"SEC. 1617. (a) Whenever benefit amounts under title II are increased by any percentage effective with any month as a result of a determination made under section 215(i)—

42 USC 415.

"(1) each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), and (b)(2) of section 1611, and subsection (a)(1)(A) of section 211 of Public Law 93-66, as specified in such subsections or as previously increased under

42 USC 1382,
411.

this section, shall be increased by the amount (if any) by which—

“(A) the amount which would have been in effect for such month under such subsection but for the rounding of such amount pursuant to paragraph (2), exceeds

“(B) the amount in effect for such month under such subsection; and

“(2) the amount obtained under paragraph (1) with respect to each subsection shall be further increased by the same percentage by which benefit amounts under title II are increased for such month (and rounded, when not a multiple of \$12, to the next lower multiple of \$12), effective with respect to benefits for months after such month.

“(b) The new dollar amounts to be in effect under section 1611 of this title and under section 211 of Public Law 93-66 by reason of this section shall be published in the Federal Register together with, and at the same time as, the material required by section 215(i)(2)(D) to be published therein by reason of the determination involved.”.

(b) The amendment made by this section shall become effective on October 1, 1982.

Publication in
Federal
Register.

42 USC 415.

Effective date.
42 USC 1382f
note.

COORDINATION OF SSI AND OASDI COST-OF-LIVING ADJUSTMENTS

SEC. 183. (a) Section 1611(c) of the Social Security Act (as amended by section 181 of this Act) is further amended—

42 USC 1382.

(1) in paragraph (1) by striking out “paragraph (2)” and inserting in lieu thereof “paragraphs (2), (3), and (4)”;

(2) by redesignating paragraphs (3) and (4) as paragraphs (5) and (6), respectively; and

(3) by inserting after paragraph (2) the following new paragraphs:

“(3) For purposes of this subsection, an increase in the benefit amount payable under title II (over the amount payable in the preceding month, or, at the election of the Secretary, the second preceding month) to an individual receiving benefits under this title shall be included in the income used to determine the benefit under this title of such individual for any month which is—

“(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1617, or

“(B) at the election of the Secretary, the month immediately following such month.

“(4)(A) Notwithstanding paragraph (3), if the Secretary determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living adjustments under other benefit programs), the benefit amount of such individual under this title for such month may be determined on the basis of such information.

“(B) The Secretary shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this title.”.

(b) The amendment made by subsection (a) shall become effective October 1, 1982.

Effective date.
42 USC 1382
note.

PHASEOUT OF HOLD HARMLESS PROTECTION

42 USC 1382e
note.

SEC. 184. (a) Section 401 of the Social Security Amendments of 1972 (Public Law 92-603) is amended by adding at the end thereof the following new subsection:

“(d) In addition to the amount which a State must pay to the Secretary for the fiscal year 1983 or the fiscal year 1984, as determined under subsection (a), the State shall also pay, for the fiscal year 1983, 60 percent of the further amount that would be payable but for the limit specified in subsection (a), and, for the fiscal year 1984, 80 percent of such further amount. For each fiscal year thereafter, the limit prescribed in subsection (a) shall be inapplicable and a State shall pay to the Secretary the full amount of any supplementary payments he makes on behalf of such State.”

Effective date.
42 USC 1382e
note.

(b) The amendment made by subsection (a) shall become effective on the date of the enactment of this Act.

EXCLUSION FROM RESOURCES OF BURIAL PLOTS AND CERTAIN FUNDS
SET ASIDE FOR BURIAL EXPENSES

42 USC 1382b.

SEC. 185. (a) Section 1613(a)(2) of the Social Security Act is amended by inserting “(A)” after “(2)”, by adding “and” after the semicolon, and by adding at the end thereof the following new subparagraph:

“(B) the value of any burial space (subject to such limits as to size or value as the Secretary may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;”

(b) Section 1613 of such Act is further amended by adding at the end thereof the following new subsection:

“Funds Set Aside for Burial Expenses

“(d)(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of \$1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse if the inclusion of any portion of such amount or amounts would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a).

42 USC 1382.

“(2) The amount of \$1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

“(3) If the Secretary finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside, he shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

“(4) The Secretary may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.”.

(c) The amendment made by this section shall take effect on the first day of the second month after the month in which this Act is enacted.

Effective date.
42 USC 1382b
note.

MANDATORY PASSTHROUGH UNDER STATE SUPPLEMENTATION PROVISIONS

SEC. 186. Section 1618 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 1382g.

“(c) Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.”.

TREATMENT OF UNNEGOTIATED CHECKS UNDER SUPPLEMENTAL SECURITY INCOME PROGRAM

SEC. 187. (a) Section 1631(i)(2) of the Social Security Act (as added by section 2343(a) of the Omnibus Budget Reconciliation Act of 1981) is amended by striking out “included in all checks payable to individuals entitled to benefits under this title but” in the first sentence and inserting in lieu thereof “included in all such benefit checks”. 95 Stat. 866.
42 USC 1383.

(b) The amendment made by subsection (a) shall become effective October 1, 1982.

Effective date.
42 USC 1383
note.

Subtitle G—Unemployment Compensation

ROUNDING OF BENEFIT AMOUNTS

SEC. 191. (a) Section 204(a)(2) of the Federal-State Extended Unemployment Compensation Act of 1970 is amended by striking out “or” at the end of clause (B), and by inserting before the period at the end thereof the following: “, or (D) paid to an individual with respect to a week of unemployment to the extent that such amount exceeds the amount of such compensation which would be paid to such individual if such State had a benefit structure which provided that the amount of compensation otherwise payable to any individual for any week shall be rounded (if not a full dollar amount) to the nearest lower full dollar amount”.

95 Stat. 884.
26 USC 3304
note.

(b)(1) Except as provided in paragraph (2), the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning on or after October 1, 1983.

Effective date.
42 USC 3304
note.

(2) In the case of a State with respect to which the Secretary of Labor has determined that State legislation is required in order to provide for rounding down of unemployment compensation amounts, the amendment made by this section shall apply in the case of compensation paid to individuals during eligibility periods which begin on or after October 1, 1983, and after the end of the first session of the State legislature which begins after the date of the enactment of this Act, or which began prior to the date of the enactment of this Act and remained in session for at least twenty-five calendar days after such date of enactment. For purposes of the preceding sentence, the term "session" means a regular, special, budget, or other session of a State legislature.

USE OF CERTAIN AMOUNTS TRANSFERRED TO STATE UNEMPLOYMENT FUNDS

SEC. 192. (a) Paragraph (2) of section 903(c) of the Social Security Act is amended—

(1) by striking out "twenty-four" each place it appears and inserting in lieu thereof "thirty-four"; and

(2) by striking out "twenty-fourth" in the second sentence and inserting in lieu thereof "thirty-fourth".

(b) Subsection (c) of section 903 of such Act is amended by adding at the end thereof the following new paragraph:

"(3)(A) If—

"(i) amounts transferred to the account of a State pursuant to subsections (a) and (b) of this section were used in payment of unemployment benefits to individuals; and

"(ii) the Governor of such State submits a request to the Secretary of Labor that such amounts be restored under this paragraph,

then the amounts described in clause (i) shall be restored to the status of funds transferred under subsections (a) and (b) of this section which have not been used by eliminating any charge against amounts so transferred for the use of such amounts in the payment of unemployment benefits.

"(B) Subparagraph (A) shall apply only to the extent that the amounts described in clause (i) of such subparagraph do not exceed the amount then in the State's account.

"(C) Subparagraph (A) shall not apply if the State has a balance of advances made to its account under title XII of this Act.

"(D) If the Secretary of Labor determines that the requirements of this paragraph are met with respect to any request, the Secretary shall notify the Governor of the State that such requirements are met with respect to such request and the amount restored under this paragraph. Such restoration shall be as of the first day of the first month following the month in which the notification is made."

TREATMENT OF CERTAIN EMPLOYEES OF INSTITUTIONS OF HIGHER EDUCATION

SEC. 193. (a) Clause (ii) of section 3304(a)(6)(A) of the Internal Revenue Code of 1954 (relating to requirements for approval of State unemployment compensation laws) is amended to read as follows:

"(ii) with respect to services in any other capacity for an educational institution to which section 3309(a)(1) applies—

treated as an employee with respect to such services for Federal tax purposes.

“(2) DIRECT SELLER.—The term ‘direct seller’ means any person if—

“(A) such person—

“(i) is engaged in the trade or business of selling (or soliciting the sale of) consumer products to any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary prescribes by regulations, for resale (by the buyer or any other person) in the home or otherwise than in a permanent retail establishment, or

“(ii) is engaged in the trade or business of selling (or soliciting the sale of) consumer products in the home or otherwise than in a permanent retail establishment,

“(B) substantially all the remuneration (whether or not paid in cash) for the performance of the services described in subparagraph (A) is directly related to sales or other output (including the performance of services) rather than to the number of hours worked, and

“(C) the services performed by the person are performed pursuant to a written contract between such person and the person for whom the services are performed and such contract provides that the person will not be treated as an employee with respect to such services for Federal tax purposes.

“(3) COORDINATION WITH RETIREMENT PLANS FOR SELF-EMPLOYED.—This section shall not apply for purposes of subtitle A to the extent that the individual is treated as an employee under section 401(c)(1) (relating to self-employed individuals).”

(b) AMENDMENT OF SOCIAL SECURITY ACT.—Section 210 of the Social Security Act is amended by adding at the end thereof the following new subsection:

“Treatment of Real Estate Agents and Direct Sellers

“(p) Notwithstanding any other provision of this title, the rules of section 3508 of the Internal Revenue Code of 1954 shall apply for purposes of this title.”

(c) INDEFINITE EXTENSION OF PROVISIONS RELATING TO EMPLOYMENT STATUS FOR EMPLOYMENT TAXES.—

(1) TERMINATION OF CERTAIN EMPLOYMENT TAX LIABILITY.—

(A) Subparagraph (A) of section 530(a)(1) of the Revenue Act of 1978 (relating to termination of certain employment tax liability for periods before July 1, 1982) is amended by striking out “ending before July 1, 1982”.

(B) Paragraph (3) of section 530(a) of such Act is amended by striking out “and before July 1, 1982,”.

(C) The subsection heading of subsection (a) of section 530 of such Act is amended by striking out “FOR PERIODS BEFORE JULY 1, 1982”.

(2) PROHIBITION AGAINST REGULATIONS AND RULINGS ON EMPLOYMENT STATUS.—Subsection (b) of section 530 of such Act is amended—

(A) by striking out “July 1, 1982 (or, if earlier,” and

(B) by striking out “taxes)” and inserting in lieu thereof “taxes”.

42 USC 410.

Ante, p. 551.

26 USC 3401
note.

26 USC 530.

26 USC 3401 *et seq.* 3101.

employer's liability for tax under chapter 24 or subchapter A of chapter 21 if such liability is due to the employer's intentional disregard of the requirement to deduct and withhold such tax.

"(d) SPECIAL RULES.—For purposes of this section—

"(1) DETERMINATION OF LIABILITY.—If the amount of any liability for tax is determined under this section—

"(A) the employee's liability for tax shall not be affected by the assessment or collection of the tax so determined,

"(B) the employer shall not be entitled to recover from the employee any tax so determined, and

"(C) sections 3402(d) and section 6521 shall not apply.

"(2) SECTION NOT TO APPLY WHERE EMPLOYER DEDUCTS WAGE BUT NOT SOCIAL SECURITY TAXES.—This section shall not apply to any employer with respect to any wages if—

"(A) the employer deducted and withheld any amount of the tax imposed by chapter 24 on such wages, but

"(B) failed to deduct and withhold the amount of the tax imposed by subchapter A of chapter 21 with respect to such wages.

"(3) SECTION NOT TO APPLY TO CERTAIN STATUTORY EMPLOYEES.—This section shall not apply to any tax under subchapter A of chapter 21 with respect to an individual described in subsection (d)(3) of section 3121 (without regard to whether such individual is described in paragraph (1) or (2) of such subsection)."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 25 is amended by adding at the end thereof the following new item:

"Sec. 3509. Determination of employer's liability for certain employment taxes."

26 USC 3509
note.

(c) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act, except that such amendments shall not apply to any assessment made before January 1, 1983.

PART II—FEDERAL UNEMPLOYMENT TAX

Subpart A—Increase in Federal Unemployment Tax

SEC. 271. INCREASE IN FEDERAL UNEMPLOYMENT TAX WAGE BASE AND RATE.

26 USC 3306.

(a) INCREASE IN WAGE BASE.—Paragraph (1) of section 3306(b) (defining wages) is amended by striking out "\$6,000" each place it appears and inserting in lieu thereof "\$7,000".

26 USC 3301.

(b) INCREASE IN RATE.—

(1) IN GENERAL.—Paragraph (1) of section 3301 (relating to rate of unemployment tax) is amended by striking out "3.4 percent" and inserting in lieu thereof "3.5 percent".

(2) TECHNICAL AMENDMENTS.—

42 USC 1101.

(A) Subparagraph (C) of section 901(c)(3) of the Social Security Act is amended to read as follows:

"(C) Each estimate of net receipts under this paragraph shall be based upon (i) a tax rate of 0.5 percent in the case of any calendar year for which the rate of tax under section 3301 of the Federal Unemployment Tax Act is 3.2 percent, and (ii) a tax rate of 0.8 percent in the case of any calendar year for which the rate of tax under such section is 3.5 percent."

26 USC 3301 *et seq.*

(B) Paragraph (1) of section 905(b) of such Act is amended by amending the last sentence to read as follows: "In the case of any month after March 1983 and before April 1 of the first calendar year to which paragraph (2) of section 3301 of the Federal Unemployment Tax Act applies, the first sentence of this paragraph shall be applied by substituting '40 percent' for 'one-tenth'." 42 USC 1105.
26 USC 3301 *et seq.*

(C) Subsection (b) of section 6157 is amended by striking out "0.7 percent" and inserting in lieu thereof "0.8 percent". 26 USC 6157.

(c) INCREASE IN RATE FOR 1985 AND THEREAFTER.—

(1) IN GENERAL.—Section 3301 (as amended by subsection (b)) is amended— 26 USC 3301.

(A) by striking out "3.5 percent" and inserting in lieu thereof "6.2 percent", and

(B) by striking out "3.2 percent" and inserting in lieu thereof "6.0 percent".

(2) INCREASE IN AMOUNT OF STATE CREDIT.—

(A) Subsection (b) of section 3302 (relating to additional credit) is amended by striking out "2.7%" and inserting in lieu thereof "5.4%". 26 USC 3302.

(B) Paragraph (1) of section 3302(d) (relating to rate of tax deemed to be 3 percent) is amended by striking out "3 percent" each place it appears and inserting in lieu thereof "6 percent".

(3) TECHNICAL AMENDMENTS.—

(A) Paragraph (2) of section 3302(c) is amended by striking out "10 percent" each place it appears in subparagraph (A) and inserting in lieu thereof "5 percent".

(B) Paragraph (3) of section 3302(c) is amended by striking out "15 percent" and inserting in lieu thereof "7½ percent".

(C) Subsection (b) of section 6157 is amended by striking out "0.5 percent" each place it appears and inserting in lieu thereof "0.6 percent". 26 USC 6157.

(D) Subparagraph (C) of section 901(c)(3) of the Social Security Act (as amended by subsection (b)) is amended— *Ante*, p. 554.

(i) by striking out "0.5 percent" and inserting in lieu thereof "0.6 percent";

(ii) by striking out "3.2 percent" and inserting in lieu thereof "6.0 percent"; and

(iii) by striking out "3.5 percent" and inserting in lieu thereof "6.2 percent".

(b) EFFECTIVE DATES.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall apply to remuneration paid after December 31, 1982. 26 USC 3301 note.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall apply to remuneration paid after December 31, 1984. 26 USC 3301 note.

(3) TRANSITIONAL RULE FOR CERTAIN EMPLOYEES.— 26 USC 3302 note.

(A) IN GENERAL.—Notwithstanding section 3303 of the Internal Revenue Code of 1954, in the case of taxable years beginning after December 31, 1984, and before January 1, 1989, a taxpayer shall be allowed the additional credit under section 3302(b) of such Code with respect to any employee covered by a qualified specific industry provision *Supra*.

advances under title XII of the Social Security Act are not less than the sum of— 42 USC 1321.

“(i) the potential additional taxes for such taxable year, and

(ii) any advances made to such State during such 1-year period under such title XII,

“(B) there will be sufficient amounts in the State unemployment fund to pay all compensation during the 3-month period beginning on November 1 of such taxable year without receiving any advance under title XII of the Social Security Act, and

“(C) there is a net increase in the solvency of the State unemployment compensation system for the taxable year attributable to changes made in the State law after the date on which the first advance taken into account in determining the amount of the potential additional taxes was made (or, if later, after the date of the enactment of this subsection) and such net increase equals or exceeds the potential additional taxes for such taxable year.

“(3) DEFINITIONS.—For purposes of paragraph (2)—

“(A) POTENTIAL ADDITIONAL TAXES.—The term ‘potential additional taxes’ means, with respect to any State for any taxable year, the aggregate amount of the additional tax which would be payable under this chapter for such taxable year by all taxpayers subject to the unemployment compensation law of such State for such taxable year if paragraph (2) of subsection (c) had applied to such taxable year and any preceding taxable year without regard to this subsection but with regard to subsection (f).

“(B) TREATMENT OF CERTAIN REDUCTIONS.—Any reduction in the State’s balance under section 901(d)(1) of the Social Security Act shall not be treated as a repayment made by such State. 42 USC 1101.

“(4) REPORTS.—The Secretary of Labor may require a State to furnish such information at such time and in such manner as may be necessary for purposes of paragraph (2).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1982. 26 USC 3302 note.

SEC. 273. LIMITATION ON FIFTH YEAR CREDIT REDUCTION.

(a) GENERAL RULE.—Paragraph (2) of section 3302(c) (relating to limit on total credits) is amended by adding at the end thereof the following new sentence: “Subparagraph (C) shall not apply with respect to any taxable year to which it would otherwise apply (but subparagraph (B) shall apply to such taxable year) if the Secretary of Labor determines (on or before November 10 of such taxable year) that the State meets the requirements of subsection (f)(2)(B) for such taxable year.” 26 USC 3302.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1982. 26 USC 3302 note.

SEC. 274. DEFERRAL OF INTEREST IN CASE OF CERTAIN STATES WITH HIGH UNEMPLOYMENT RATES.

(a) GENERAL RULE.—Paragraph (3) of section 1202(b) of the Social Security Act is amended by adding at the end thereof the following new subparagraph: 95 Stat. 879.
42 USC 1322.

“(C)(i) In the case of any State which meets the requirements of clause (ii) for any calendar year, any interest otherwise required to be paid under this subsection during such calendar year shall be paid as follows—

“(I) 25 percent of the amount otherwise required to be paid on or before any day during such calendar year shall be paid on or before such day; and

“(II) 25 percent of the amount otherwise required to be paid on or before such day shall be paid on or before the corresponding day in each of the 3 succeeding calendar years.

Any interest the time for payment of which is deferred under this subparagraph shall bear interest in the same manner as if it were an advance made on the day on which it would have been required to be paid but for this subparagraph.

“(ii) A State meets the requirements of this clause for any calendar year if the rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970) under the State law of the period consisting of the first 6 months of the preceding calendar year equaled or exceeded 7.5 percent.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to interest required to be paid after December 31, 1982.

SEC. 275. REQUIRED REPAYMENTS FROM EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.

Subsection (d) of section 905 of the Social Security Act is amended by inserting after the second sentence the following new sentence: “Repayments under the preceding sentence shall be made whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount then in the account exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months.”

SEC. 276. TREATMENT OF CERTAIN SERVICES PERFORMED BY STUDENTS.

(a) **STUDENT INTERNS.**—

(1) **IN GENERAL.**—Subparagraph (C) of section 3306(c)(10) (defining employment) is amended by striking out “under the age of 22”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to services performed after the date of the enactment of this Act.

(b) **FULL TIME STUDENTS EMPLOYED BY SUMMER CAMPS.**—

(1) **SERVICE BY FULL TIME STUDENTS.**—Subsection (c) of section 3306 (defining employment) is amended—

(A) by striking out “or” at the end of paragraph (18),

(B) by striking out the period at the end of paragraph (19) and inserting in lieu thereof “; or”, and

(C) by adding at the end thereof the following new paragraph:

“(20) service performed by a full time student (as defined in subsection (q)) in the employ of an organized camp—

“(A) if such camp—

“(i) did not operate for more than 7 months in the calendar year and did not operate for more than 7 months in the preceding calendar year, or

“(ii) had average gross receipts for any 6 months in the preceding calendar year which were not more than

26 USC 3304
note.

42 USC 1322
note.

42 USC 1105.

26 USC 3306.

26 USC 3306
note.

26 USC 3306.

only with respect to the tax imposed by section 1401(b), remuneration paid for medicare qualified Federal employment (as defined in section 3121(u)(2)) which is subject to the taxes imposed by sections 3101(b) and 3111(b)".

Ante, p. 559.

(3) CONFORMING AMENDMENT TO FEDERAL SERVICE.—Section 3122 (relating to federal service) is amended in the first sentence by inserting "including service which is medicare qualified Federal employment (as defined in section 3121(u)(2))," after "wholly owned by the United States,".

(b) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

42 USC 410.

(1) DEFINITION OF MEDICARE QUALIFIED FEDERAL EMPLOYMENT.—Section 210 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Medicare Qualified Federal Employment

42 USC 426,
426-1.

"(p) For purposes of sections 226 and 226A, the term 'medicare qualified Federal employment' means any service which would constitute 'employment' as defined in subsection (a) of this section but for the application of the provisions of—

"(1) subparagraph (A), (B), or (C)(i), (ii), or (vi) of subsection (a)(6), or

"(2) subsection (a)(5)."

(2) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

42 USC 426.

(A) FOR INDIVIDUALS AGE 65 OR OLDER.—Section 226(a)(2) of the the Social Security Act is amended—

(i) by inserting "(A)" after "(2)";

(ii) by striking out "or is a qualified railroad retirement beneficiary," at the end of subparagraph (A); and

(iii) by inserting after subparagraph (A) the following new subparagraphs:

"(B) is a qualified railroad retirement beneficiary, or

"(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified Federal employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,".

Supra.

42 USC 1395c.

(B) ENTITLEMENT FOR DISABLED INDIVIDUALS.—

(i) IN GENERAL.—Section 226(b)(2) of the Social Security Act is amended by striking out "(B)" and all that follows through "1974," and adding at the end the following:

45 USC 231f.

"(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974, or

"(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII pursuant to this subparagraph, and

"(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this title), including the requirement that he has been entitled to the specified benefits for 24 months, if—

"(I) medicare qualified Federal employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and

"(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),".

(ii) **CLARIFICATION OF PERIOD OF ENTITLEMENT.**—Section 226(b) of such Act is further amended by adding after the first sentence the following new sentence: "In applying the previous sentence in the case of an individual described in paragraph (2)(C), the 'twenty-fifth month of his entitlement' refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and 'notice of termination of such entitlement' refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph." 42 USC 426.

(C) **ENTITLEMENT FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.**—Paragraph (1) of section 226A(a) of the Social Security Act is amended to read as follows: 42 USC 426-1.

"(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included within the meaning of the term 'employment' for purposes of this title, and (ii) his medicare qualified Federal employment (as defined in section 210(p)) were included within the meaning of the term 'employment' for purposes of this title; 45 USC 231t.

"(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974, or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified Federal employment (as defined in 210(p)) after December 31, 1982, were included within the meaning of the term 'employment' for purposes of this title; or Ante, p. 560.

"(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);".

(3) **CONFORMING AMENDMENT.**—Section 1811 of the Social Security Act is amended— 42 USC 1395c.

(A) by inserting "(or would be eligible for such benefits if certain Federal employment were covered employment under such title)" after "title II of this Act" in clause (1), and

(B) by inserting "(or would have been so entitled to such benefits if certain Federal employment were covered employment under such title)" after "title II of this Act" in clause (2).

(4) **NOTICE TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON FEDERAL EMPLOYMENT.**—Section 226 of such Act is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection: 42 USC 426.

"(g) The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform medicare qualified Federal employment are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (2) the requirements for 42 USC 1395c.

and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity under chapter 83 of title 5, United States Code, or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.”

(c) EFFECTIVE DATES.—

(1) HOSPITAL INSURANCE TAXES.—The amendments made by subsection (a) shall apply to remuneration paid after December 31, 1982.

(2) MEDICARE COVERAGE.—

(A) IN GENERAL.—The amendments made by subsection (b) are effective on and after January 1, 1983, and the amendments made by paragraph (3) of that subsection apply to remuneration (for medicare qualified Federal employment) paid after December 31, 1982.

(B) TREATMENT OF CURRENT DISABILITIES.—For purposes of establishing entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act pursuant to the amendments made by subsection (b) or the provisions of subsection (d), no individual may be considered to be under a disability for any period before January 1, 1983.

(d) TRANSITIONAL PROVISIONS.—

(1) IN GENERAL.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual—

(A) who performs service both during January 1983, and before January 1, 1983, which constitutes medicare qualified Federal employment (as defined in section 210(p) of such Act) and

(B) who would be entitled, under section 226(a)(2)(C), 226(b)(2)(C), 226A(a)(1)(A)(ii), or 226A(a)(1)(B)(iii) of such Act, to hospital insurance benefits under part A of title XVIII of such Act but for the failure to include medicare qualified Federal employment (as so defined) within the meaning of the term “employment” for purposes of title II of such Act for remuneration paid before January 1, 1983,

the individual’s medicare qualified Federal employment (as so defined) performed before January 1, 1983, for which remuneration was paid before such date, shall be considered to be “employment” (as so defined), but only for the purpose of providing such entitlement.

(2) ELIGIBILITY OF OTHER PERSONS.—Any individual who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of the application of paragraph (1) of this subsection, shall be deemed to be entitled to an old-age benefit under section 202 of such Act, or a disability benefit under section 223 of such Act, for purposes of determining eligibility for such hospital insurance benefits for any other person. In applying this paragraph, any such other person who would be entitled to a monthly benefit under section 202 of such Act if such individual (to whom paragraph (1) applies) were entitled to such old-age or disability benefit, shall be deemed to be entitled to such monthly benefit, but only for purposes of determining such person’s eligibility for hospital insurance benefits.

5 USC 8301 *et seq.*

26 USC 3121 note.

42 USC 426 note.

42 USC 1395c.

42 USC 426 note.

42 USC 426, 426-1, 1395c.

Ante, pp. 560, 561.

42 USC 401.

42 USC 402.

42 USC 423.

(3) APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year, on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1) or (2) of this subsection, 42 USC 1395.

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

Subtitle F—Excise Taxes

PART I—AIRPORT AND AIRWAY

SEC. 279. TAX ON FUEL USED IN NONCOMMERCIAL AVIATION.

(a) IMPOSITION OF TAX.—

(1) GASOLINE FUELS.—Paragraph (3) of subsection 4041(c) 26 USC 4041. (relating to rate of tax) is amended by striking out “3 cents a gallon” and inserting in lieu thereof “8 cents a gallon (10½ cents a gallon in the case of any gasoline with respect to which a tax is imposed under section 4081 at the rate set forth in subsection (b) thereof)”.

(2) NONGASOLINE FUELS.—Paragraph (1) of subsection 4041(c) (relating to tax on fuel used in noncommercial aviation) is amended by striking out “7 cents” and inserting in lieu thereof “14 cents”.

(3) TERMINATION.—Paragraph (5) of section 4041(c) is amended to read as follows:

“(5) TERMINATION.—The taxes imposed by paragraphs (1) and (2) shall apply during the period beginning on September 1, 1982, and ending on December 31, 1987.”

(b) CERTAIN HELICOPTERS.—

(1) EXEMPTION.—Section 4041 (relating to tax on special fuels) is amended by adding at the end thereof the following new subsection:

“(1) EXEMPTION FOR CERTAIN HELICOPTER USES.—No tax shall be imposed under this section on any liquid sold for use in, or used in, a helicopter for the purpose of—

“(1) transporting individuals, equipment, or supplies in the exploration for, or the development or removal of, hard minerals, or

“(2) the planting, cultivation, cutting or transportation of, or caring for, trees (including logging operation),

but only if the helicopter does not take off from, or land at, a facility eligible for assistance under the Airport and Airway Development Act of 1970, or otherwise use services provided pursuant to the Airport and Airway Improvement Act of 1982 during such use.”

49 USC 1701
note.

(2) REFUND OF TAX.— Subsection (d) of section 6427 (relating to fuels not used for taxable purposes) is amended—

Post, p. 671.
26 USC 6427.

(A) the amendments made by this section shall be applied by taking into account the entire amount of unemployment compensation received during such taxable year, but

(B) the increase in gross income for such taxable year as a result of such amendments shall not exceed the amount of unemployment compensation paid after December 31, 1981.

(4) **UNEMPLOYMENT COMPENSATION DEFINED.**—For purposes of this subsection, the term “unemployment compensation” has the meaning given to such term by section 85(c) of the Internal Revenue Code of 1954.

Approved September 3, 1982.

LEGISLATIVE HISTORY—H.R. 4961:

HOUSE REPORTS: No. 97-404 (Comm. on Ways and Means) and No. 97-760 (Comm. of Conference).

SENATE REPORTS: No. 97-494 Vols. 1 and 2 (Comm. on Finance) and No. 97-530 (Comm. of Conference).

CONGRESSIONAL RECORD:

Vol. 127 (1981): Dec. 15, considered and passed House.

Vol. 128 (1982): July 19-22, considered and passed Senate, amended.

Aug. 19, House and Senate agreed to conference report.



MISCELLANEOUS REVENUE ACT
OF 1981

REPORT
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 4961

together with DISSENTING VIEWS

[Including cost estimate of the Congressional Budget Office]



DECEMBER 14, 1981.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MISCELLANEOUS REVENUE ACT OF 1981

DECEMBER 14, 1981.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

R E P O R T

together with DISSENTING VIEWS

[To accompany H.R. 4961]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4961) to make miscellaneous changes in the tax laws, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended to pass.

The amendments are shown in the reported bill, with the matter proposed to be stricken shown in linetype and the matter proposed to be inserted shown in italic.

The title of the bill is amended to reflect the amendments to the text of the bill.

B. TITLE II—UNEMPLOYMENT COMPENSATION AND WELFARE PROVISIONS

Title II of H.R. 4961 contains amendments to the Federal-State unemployment compensation program, the Supplemental Security Income (SSI) program, the Child Support Enforcement program (CSE) and the social services program established under title XX of the Social Security Act.

Unemployment Compensation Amendments

Section 201: Reed Act Extension (Section 903(c)(2) of the Social Security Act).—Extends for 10 years the authority for States to use for administrative purposes certain funds credited to individual State unemployment trust fund accounts in 1956, 1957, and 1958; and, allows States that have used such funds to pay unemployment benefits to reestablish a Reed Act Account.

Section 202: Exclusion of Student Intern Wages from FUTA (Section 3306(c)(10)(C) of the Internal Revenue Code).—Excludes from Federal unemployment taxes wages paid to certain student interns, regardless of age, for work that is an integral part of their academic program. Currently, only interns under age 22 are excluded.

Section 203: Exclusion of Wages Paid to Certain Alien Farmworkers from FUTA (Section 3306(c)(1)(B) of the Internal Revenue Code).—Extends for 2 years the exclusion of wages paid to aliens admitted to the U.S. to perform agricultural work, pursuant to the Immigration and Nationality Act, from Federal unemployment taxes.

Section 204: Unemployment Compensation Benefits for Ex-Servicemembers (Section 2405, P.L. 97-35).—Limits unemployment benefits to ex-servicemembers who have served 730 or more continuous days in the military; requires a 4-week waiting period between the week in which the individual is separated from the service and the week in which he or she first becomes entitled to compensation; and, limits an eligible ex-servicemember's benefits to 13 weeks. Effective for separation on or after July 1, 1981, but only for benefits payable after the date of enactment.

Supplemental Security Income, Child Support Enforcement, and Social Services Amendments

Section 205: One Month Prospective Budgeting for SSI Benefits (Section 1611(c)(11) of the Social Security Act).—Substitutes a one-month "prospective" accounting period in SSI for the "retrospective" accounting period in current law.

Section 206: Negotiability of SSI Checks (Section 1631(i)(2) of the Social Security Act).—Clarifies that new provisions establishing a process for dealing with unnegotiated SSI checks apply to "State supplement-only checks" as well as SSI/State supplement checks.

Section 207: Child Support Enforcement—Cost of Collection and Other Services (Section 454 of the Social Security Act, as amended).—Repeals provisions in current law that *require* States to charge the absent parent an amount equal to 10 percent of any child support collected for a non-AFDC recipient. Allows States to charge a fee of up to \$20 and retain from any non-AFDC collection an amount equal to administrative costs not covered by the fee, or to collect this amount from the parent who owes child or spousal support.

Section 208: Child Support Enforcement—Technical Amendments.—Corrects several inaccurate references contained in the fiscal 1982 Budget Reconciliation Bill.

Section 209: Social Services—Technical Amendments (Title XX of the Social Security Act, as amended).—Conforms FY 1982 Reconciliation bill provisions to allow the Territories to continue to spend unused public assistance funds for social services; makes a technical correction to ensure that all title XX funds are available for allotment to States and territories; clarifies provisions in current law so the definition of "State" for title XX purposes is the same as under prior law; conforms the title IV-E Foster Care program to changes contained in Omnibus Reconciliation Act of 1981.

A. Unemployment Compensation Amendments

1. Section 201: Use of Certain Amounts Transferred to State Unemployment Funds (Reed Act)

Section 201 would extend for 10 years the period during which Reed Act funds may be used for administrative purposes, and would permit those States which have used Reed Act funds to pay unemployment benefits to restore their Reed Act accounts.

Under current law, section 903 of the Social Security Act, enacted in 1954, commonly referred to as the Reed Act, requires that any excess Federal unemployment tax (FUTA) receipts be credited to the individual State accounts in the unemployment trust fund. Each State's share is proportionate to its share of wages subject to FUTA taxes. Prior to that date, FUTA revenues had frequently exceeded the obligations against the tax and excess collections were transferred to general revenues.

Excess funds have occurred only three times since passage of the Reed Act—in 1956, 1957, and 1958. A total of \$138 million was allocated among the States for the three year period. Current unobligated Reed Act account balances of the States, as of June 30, 1981, totaled some \$25 million.

Reed Act funds may be used for two purposes: (1) the payment of unemployment benefits, or (2) the payment of expenses incurred in the administration of a State's unemployment compensation law. Administrative expenditures are limited and must be pursuant to a specific State legislative appropriation outlining the amounts and intended use of monies withdrawn from the State's Reed Act account.

If Reed Act funds are used for a major capital expenditure, such as the construction or purchase of a building, the amount so appropriated can be recovered through amortization or rental funds received from employment service/unemployment insurance administrative grants. This allows a State, to the extent the funds are used for major capital expenditures, to replenish and then reuse their Reed Act money. It is because a number of States have used their funds for such capital expenditures that a substantial amount of the Reed Act money distributed in 1956, 1957 and 1958 is still available. Only amortization and rent (in a rental purchase arrangement) can be redeposited to the Reed Act account. Amounts appropriated for other administrative purposes, such as purchase of equipment, are not recoverable and any return from these uses becomes a part of the State's Trust Fund reserves.

Under current law, authority for States to use the 1956 portion of Reed Act funds for administrative purposes expired on July 1, 1981.

Authority to use for administrative purposes Reed Act funds created in 1957 expires on July 1, 1982; and administrative authority for the 1958 funds expires July 1, 1983.

The Committee believes that extending the Reed Act, and permitting States that have been required to use Reed Act funds to pay unemployment benefits to restore their Reed Act accounts, will strengthen the Federal-State unemployment system. States have used Reed Act funds to pay administrative program costs for which Federal grant funds were not available. For example, funds have been used to pay for outside audits of employment security records. In addition, many States have utilized Reed Act funds to finance major capital expenditures, such as the construction of employment security offices. The Subcommittee believes these investments have resulted in substantial cost savings, in terms of reduced expenditures for leasing facilities, and improvements in the operations of State unemployment security programs.

2. Section 202: Treatment of Certain Services Performed by Students

Under current law, wages paid to a student under age 22, who is a full-time student enrolled in a work-study or internship program, are excluded from the Federal unemployment tax (FUTA) if the work performed is an integral part of the student's academic program. Section 202 would remove the age limitation so that student intern wages would be exempt from FUTA regardless of the age of the student.

The exemption in current law pertaining to student interns was enacted in 1970. The Committee has been unable to find any explanation in the materials that accompanied the 1970 amendment for the age limitation. Presumably it was based on the assumption that most students would likely be under age 22. While the current age limitation is sufficient to cover most undergraduate students, it does not cover most graduate-level programs. In addition, school attendance at all educational levels by those over age 22 has grown tremendously in recent years. For example, veterans and others often work for a period of time before engaging in post-high school studies.

Many schools and educational institutions combine outside work experience with formal class-room study. The work portion of these programs is integrated into the regular curriculum and is a required component of the educational program. The Committee does not believe that work performed by a student which is a required component of an integrated work-study curriculum involves the kind of employment or the employer-employee relationship that was intended to be covered by the unemployment insurance system. Therefore, the wages paid to these student interns should not be taxable under the Federal unemployment compensation law. Accordingly, the Committee finds no basis for the present age 22 limitation.

3. Section 203: Treatment of Certain Alien Farm Workers

Section 203 would extend for 2 years—from January 1, 1982 to January 1, 1984—the temporary exclusion in present law that exempts employers from paying Federal unemployment taxes (FUTA) on wages paid to certain alien farmworkers.

B. Supplemental Security Income (SSI), Child Support Enforcement (CSE), and Title XX Social Services

1. Section 205: SSI Accounting Period

Section 205 substitutes a one-month "prospective" accounting period in SSI for the "retrospective" accounting period required under provisions enacted as part of the Fiscal 1982 Budget Reconciliation Act.

Under the SSI law in effect through March 1982, computation of SSI eligibility and amount of benefits is based on the income and resources for the current calendar quarter. The Omnibus Budget Reconciliation Act of 1981, however, requires that, after March 1982, the computation period for determination of eligibility and amount of SSI benefits will be on a monthly basis. *Benefits*, generally, will be determined on a monthly *retrospective* basis. That is, the amount of the SSI benefit for any month will be determined on the basis of the individual's or couple's income, resources, and other circumstances in the preceding month or, at the discretion of the Secretary of Health and Human Services, the second preceding month. The SSI payment received in June 1982, for example, will not reflect the amount of any other income the recipient had in June, it will reflect the amount of any such income the person received in April.

The objective of this change in SSI was to reduce program costs by reducing the number of erroneous payments. Because benefits are computed on the basis of the recipient's *actual* income in a prior month, rather than *projected* income for a current or future month, it was assumed that retrospective accounting would reduce errors and thereby reduce SSI costs.

The Committee, however, has been informed by the Administration and States that the retrospective accounting procedure required under the Reconciliation bill will *increase* rather than decrease SSI costs. Furthermore, it will create an erratic fluctuation in SSI benefits for those SSI recipients who also receive Social Security payments or other automatically adjusted benefits such as Veterans, Black Lung or Railroad Retirement benefits. In addition, it is highly questionable as to how much if any savings would be achieved through a reduction in errors.

The primary reason retrospective accounting will not produce the savings assumed in the Reconciliation bill is that approximately 90 percent of all non-SSI income received by SSI recipients is Social Security benefits; and, another 2 percent is Veterans, Railroad Retirement or Black Lung Benefits. Only 3 percent of all non-SSI income received by SSI recipients is from earnings.

In other words, 92 percent of all non-SSI income is from Federal programs, the benefits of which are increased once a year according to automatic cost-of-living provisions that reflect changes in the Consumer Price Index. Information on the amount of the annual adjustment in the payments under these programs is available to the Social

Security Administration, which administers the SSI program. Because the Social Security Administration has access to information on almost all of the fluctuation that occurs in the non-SSI income of SSI recipients, the primary justification for a retrospective accounting period—to achieve a reduction in errors by obtaining more accurate information on fluctuations in other income—has little relevance in the case of the SSI program.

Under a retrospective accounting system, which computes benefits on the basis of recipient income in prior months, Social Security, Veterans and other Federal benefit increases will not be counted as income in the first months that they are received. Therefore, SSI payments in July and August, increased by cost-of-living adjustments in the SSI program, will not reflect similar increases in Social Security, Veterans and other Federal pensions. SSI recipients receiving these other benefits will be paid two months of SSI payments each year that do not take into account actual increases in these automatically adjusted pensions. For these two months, SSI recipients will, in effect, be overpaid. However, in September and months thereafter, SSI payments will be reduced because of the increased Social Security or other Federal benefits. In other words, a person's SSI check will be increased in July and August and then decreased (but remaining higher than the amount received in June) in September. These changes in the amount of a person's SSI check (3 different amounts in a four-month period) will result in substantial confusion among SSI recipients.

Waiting two months to count new income or increases in Federal pensions that are known and predictable (such as the yearly automatic increase in Social Security benefits) will increase SSI expenditures over what they would have been under the law prior to the Reconciliation bill. The Administration estimates that not counting Social Security increases for two months will increase SSI costs by approximately \$50 million in fiscal 1982. The Congressional Budget Office estimates that this two-month delay resulting from retrospective accounting will increase SSI costs by \$69 million in fiscal 1982. The State of California estimates that, in addition to the increase in Federal costs, retrospective accounting will increase California's expenditures for SSI supplemental payments by \$16.4 million in fiscal 1982. There will be similar cost increases in other States that supplement the Federal SSI payment. These cost increases will be repeated each year, with the amount of the increase depending upon the percentage increase in Social Security and other automatically adjusted benefits.

It is highly questionable as to how much savings will result from a decrease in erroneous payments under retrospective accounting; certainly nowhere near the amount that will be lost due to the two-month delay in counting increases in Social Security and other benefits. Currently, most SSI erroneous payments are caused by recipients' failure to report changes in circumstances and agency caused errors, neither of which will necessarily be corrected through retrospective accounting. It appears that a limited reduction of erroneous payments would only slightly reduce the increased costs associated with the retrospective accounting system mandated by the Reconciliation bill.

The amendments in section 205 will return SSI to a "prospective" accounting system, which will allow SSI payments to be adjusted to take account of increases in Social Security and other indexed benefits the first month in which the recipient receives any such increases. The amendment will change prior law from a *quarterly* prospective to a *one-month* prospective period. With monthly rather than quarterly accounting, SSI cases should be reviewed more frequently and, as a result, changes in circumstances that affect the payment amount should be detected more quickly.

2. Section 206: Treatment of Unnegotiated Checks Under SSI Program

Section 206 clarifies that the provisions in the Omnibus Budget Reconciliation Act of 1981 establishing a procedure in the SSI program for dealing with unnegotiated checks apply to "State supplement-only" checks as well as SSI/State supplement checks.

Under current Federal law there is no time limit on the negotiability of U.S. Treasury checks issued for the purpose of providing SSI benefits.

Over half the States have agreements with the Social Security Administration to include State-funded supplementation of the Federal SSI benefit in the check issued by the U.S. Treasury. Some SSI recipients, for whom SSI is a supplement to social security or other income, qualify for a payment only because the State has chosen to increase the income eligibility standard by providing a State supplementation of the Federal SSI benefit standard. Therefore, while the U.S. Treasury issues the check, in the case of some recipients, the benefits are entirely State financed.

The Reconciliation bill amends title XVI (SSI) of the Social Security Act to establish a process for dealing with benefit checks remaining unnegotiated for more than 180 days, and for crediting States with their share (included as State supplementation) of those checks. However, the language of the Budget Reconciliation bill is not clear as to the authority to credit States for unnegotiated benefit checks which are State-supplementation only checks. It was the intent of the original provision that such checks be included in the procedure dealing with unnegotiated checks. This section clarifies that intent.

3. Section 207: Collection of Administrative Costs for Non-AFDC Enforcement

Section 207 repeals the provisions enacted in the Omnibus Budget Reconciliation Act of 1981 that require all States, in cases involving non-AFDC families, to charge any absent parent who is obligated to pay child support through the State Child Support Enforcement Agency a fee equal to 10 percent of the child support payment to cover the Agency's administrative costs. Section 207 allows States to (1) charge a fee of up to \$20 for a non-AFDC collection and retain an amount equal to administrative costs not covered by the fee, or (2) collect from the parent who owes child or spousal support an amount to cover administrative costs, in addition to the child support payment.

States are required to provide child support collection services to non-AFDC families requesting assistance. Prior to the Omnibus Re-

conciliation Act of 1981, States had the option, in the case of non-AFDC families, of charging a fee of up to \$20 and then retaining a portion of any child support collection to pay for administrative expenses not covered by the fee. Under the Reconciliation bill provisions, States have the option of charging an application fee up to \$20, but are required to charge a fee equal to 10 percent of the support collected for non-AFDC recipients who use the child support enforcement agency's collection services. The 10 percent fee is charged against the absent parent and added to the amount of the collection.

According to the Council of State Child Support Enforcement Administrators, the Reconciliation bill provision will cost the Federal government between \$10 and \$20 million in lost child support collections, rather than increase collections by \$50 million as was initially estimated; and there will be additional costs to the States. The primary reason for the anticipated reduction in collections is that the provision requires the absent parent to pay the 10 percent fee after all arrearages are satisfied. In other words, the fee is charged only to those who remain completely current in their child support obligation. This provides an incentive for the absent parent to fall behind in his payments in order to avoid the 10 percent additional cost.

The provision in the Reconciliation bill could have the effect of increasing by 10 percent the amounts of child support obligations previously established by a Court. As a result, it could require that these cases go back to court and be reopened so the amount of the monthly obligation can be increased by 10 percent. This would obviously involve an enormous amount of court time and substantial administrative expense. Furthermore, a judge could, because of the circumstances of the absent parent, simply reduce the amount of the monthly obligation so the support payment plus the 10 percent fee is no higher than the current child support obligation. This will defeat the purpose of the amendment and result in reduced support for the children.

In some States, all court-ordered child support payments are made through the State child support agency, whether or not the family involved ever contacted the agency or used any of its services. In these States, the effect of the Reconciliation bill provision will be to charge all absent parents who are making court-ordered child support payments a 10 percent fee to cover administrative costs of the child support agency, even in those cases where the agency was never involved and there were no State administrative costs in the collection of the support.

Section 207 reinstates the options in prior law under which the State could recover administrative expenses by charging a fee and retaining a portion of the amount collected. In addition, this section provides States the alternative option of charging the absent parent who owes child support an amount, in addition to the support payment, equal to administrative costs.

4. Section 208: Technical Amendments to Child Support Enforcement Provisions in Reconciliation Act

Section 208 makes several technical corrections in the Child Support Enforcement amendments contained in the Fiscal 1982 Budget Reconciliation bill, including the correction of inaccurate references.

5. Section 209: Technical Amendments to Social Services and Foster Care Provisions in Reconciliation Act

Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands are each eligible for Federal matching funds under the cash assistance titles of the Social Security Act. This includes the Aid to Families with Dependent Children program authorized under title IV and the State plan programs for aid to the aged, blind and disabled under titles I, X, XIV and XVI. (Residents of Puerto Rico, Guam and the Virgin Islands are not eligible for Supplemental Security Income.) There is a ceiling specified in Section 1108 of the Social Security Act as to the total amount of Federal matching funds available to each of these jurisdictions under these cash assistance titles.

Prior to the Omnibus Budget Reconciliation Act of 1981, these jurisdictions could also utilize funds they received under the cash assistance titles for social services. In addition, they received funds under the title XX program for social services to be used pursuant to the social services authorization for such jurisdictions in the cash assistance titles.

The Reconciliation Act unintentionally repealed the authority for these jurisdictions to finance social services from funds they receive under the cash assistance titles, and provided that these territories are eligible for funds for social services only under the title XX social services block grant.

Section 209 would restore the option to Puerto Rico, Guam and the Virgin Islands and the Northern Marianna Islands to utilize funds available to them under the cash assistance titles for social services.

Prior to the Budget Reconciliation Act, Puerto Rico, Guam, the Virgin Islands and the Northern Marianna Islands were each allotted a specified amount of title XX funds. These funds were outside of and in addition to the title XX entitlement ceiling under which funds were allocated to the States and the District of Columbia on the basis of population. In the statutory formula in the Budget Reconciliation Act, the States, the District of Columbia, Puerto Rico, the Virgin Islands and the Northern Marianna Islands were all to be subject to the same percentage reduction in funding under the new overall limit on funds under the title XX social services block grant. However, as drafted the formula can be interpreted in such a way that a portion of the title XX funds would not be available for allocation to any State or other jurisdiction.

Section 209 makes technical changes in the title XX allotment formula to insure that all the title XX funds under the ceiling are available for allotment to the States and other jurisdictions.

The Budget Reconciliation Act unintentionally changed the general definition of the term "State" in title XI of the Social Security Act as it pertains to those jurisdictions eligible for title XX funds. As a result, the definition of "State" is now inconsistent with the list of jurisdictions specifically cited in title XX as eligible for an allotment of title XX funds.

Section 209 would make the title XI definition of the term "State", as it pertains to title XX funding, consistent with the list of jurisdictions cited in title XX as eligible for funds under the allotment formula.

Federal matching funds are available to State under title IV-E of the Social Security Act for foster care provided in foster family homes or child care institutions. Prior to the Budget Reconciliation Act, States were required, by reference to a provision in title XX, to apply certain standards for such foster family homes and child care institutions. This included standards relating to admissions policies, safety, sanitation, and protection of civil rights.

The Budget Reconciliation Act made a number of changes in the title XX law, including the elimination of the requirement (referred to in title IV-E) for States to establish and monitor standards for foster family homes or foster care institutions if title XX funds are used for the provision of services to children in such homes or institutions. The Budget Reconciliation Act does continue a requirement under the title IV-E foster care program for States to have standards in effect for foster family home or child care institutions. However, the standards referred to incorrectly relate to child day care standards instead of foster care standards.

Section 209 would incorporate into the title IV-E foster care law the same standards for the foster care as were previously required by reference to the standards in title XX which were in effect prior to the Reconciliation Act.

Title II—Unemployment compensation and welfare provisions

Title II of this bill is estimated to reduce fiscal year budget outlays by \$18 million in 1982 and to increase outlays by \$53 million in 1983, \$50 million in 1984, \$54 million in 1985, and \$53 million in 1986. These estimates are in accordance with the Congressional Budget Office estimates for Title II of H.R. 4961.

BUDGET AUTHORITY AND OUTLAY ESTIMATES FOR TITLE II OF H.R. 4961

[In millions of dollars]

Item	Fiscal year—				
	1982	1983	1984	1985	1986
<i>Reed Act Extension</i>					
Required budget authority					
Estimated outlays					
<i>Removal of Age Limitation for Exclusion from FUTA of Wages Paid To Student Interns</i>					
Revenue and budget authority	(*)	(*)	(*)	(*)	(*)
Estimated outlays					
<i>Extension of Exclusion from FUTA of Wages Paid to Certain Aliens, Farmworkers</i>					
Revenue and budget authority	-1	-1			
Estimated outlays					
<i>UCX Restructuring</i>					
Required budget authority	51	76	69	65	62
Estimated outlays	51	76	69	65	62
<i>Change to Prospective Accounting Period for SSI</i>					
Required budget authority	-69	-23	-19	-11	-9
Estimated outlays	-69	-23	-19	-11	-9
<i>Clarification of Provisions Governing Negotiability of SSI Checks</i>					
Required budget authority	(*)	(*)	(*)	(*)	(*)
Estimated outlays	(*)	(*)	(*)	(*)	(*)
<i>Child Support Enforcement Fee</i>					
Required budget authority					
Estimated outlays					
<i>CSE Technical Amendments</i>					
Required budget authority					
Estimated outlays					
<i>Social Services Technical Amendments</i>					
Required budget authority					
Estimated outlays					
Total					
Revenue and budget authority	-1	-1			
Required budget authority	-18	53	50	54	53
Estimated outlays	-18	53	50	54	53

*Less than \$500,000.

NOTE.—The costs of this bill fall within budget function 600.

Vote of the Committee

In compliance with clause 3(1)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made about the vote of the committee on the motion to report the bill. The bill, H.R. 4961, as amended, was ordered favorably reported by voice vote.

TITLE II—UNEMPLOYMENT COMPENSATION AND WELFARE PROVISIONS

Oversight Findings

In compliance with clause 2(1)(3)(A) of Rule XI, the following summary of the oversight findings of the committee with respect to the changes proposed by title II of H.R. 4961 is provided.

Part A. Unemployment compensation: Extension of the Reed Act and permitting states which used Reed Act funds to pay unemployment benefits to restore their accounts, will strengthen the Federal-State unemployment compensation system. The use of Reed Act funds has resulted in substantial program cost savings and improvements in state employment security system.

Many educational institutions combine outside work experience with formal class-room study in a integrated full-time academic program. Student intern work which is a part of such programs does not involve the kind of employer-employee relationship that should be covered by the unemployment insurance system. Therefore, the wages paid to these student interns should not be taxable under the Federal unemployment compensation law.

The provision of current law which exempts wages paid to certain alien farmworkers from the Federal Unemployment Tax (FUTA) expires on December 31, 1981. A temporary 2 year exclusion should be continued until the unemployment tax issues involved can be further assessed.

Although designed to produce parity between civilian and military "workers", current law regarding unemployment compensation for exservicemembers applies more stringent unemployment benefit eligibility criteria to ex-military personnel than is applied to civilians. A modification of current law and limiting eligibility for unemployment benefits to those persons who have completed a more lengthy period of service is appropriate.

Part B. SSI, Child support enforcement, and Title XX: The FY 1982 Budget Reconciliation bill made changes in the SSI program designed to compute benefit payments more accurately on the basis of income and resources in the month preceding actual payment (or at the discretion of the Secretary, the second preceding month). However, your Committee has been informed by the Administration that the provisions will cause an erratic fluctuation in benefits for some recipients and will increase program costs. SSI benefits determined on a prospective monthly basis will improve program administration and reduce costs.

Current law does not clearly apply procedures established by the FY 1982 Reconciliation bill for dealing with un negotiated SSI checks to "State supplement-only checks" as well as SSI/State Supplement checks. The Committee bill clarifies this authority.

A provision enacted in the FY 1982 Reconciliation bill regarding the cost of collection for child support enforcement services may indirectly

encourage delinquent child and spousal support payments. The Committee bill reenstates previous law on this matter. In addition, the Committee bill clarifies authority of State child support enforcement agencies to collect spousal support for non-AFDC, as well, as AFDC recipients.

Conforming amendments to provisions in the FY 1982 Reconciliation bill regarding title XX are required to permit the Territories to continue to spend unused public assistance funds for social services, to ensure that all title XX funds are available to allotment, and to conform the title IV-E foster care program to the Reconciliation bill.

Committee Budget Estimate

In compliance with clause 7(a) of Rule XVIII of the Rules of the House of Representatives, the following statement is made: the committee agrees with the cost estimate prepared by the Congressional Budget Office which is included below.

New Budget Authority and Tax Expenditures

With respect to clause 2(1)(3)(B) of Rule XI of the Rules of the House, the committee advises that the required information pertaining to new budget authority or new or increased tax expenditures, to the extent applicable to this bill, is contained in the Congressional Budget Office cost estimate included below.

Cost Estimate Prepared by Congressional Budget Office

In compliance with clause 2(1)(3)(C) of Rule XI, requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the Congressional Budget Office is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., December 11, 1981.

Re Title II—Unemployment Compensation and Welfare Provisions.

Hon. DAN ROSTENKOWSKI,

Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act, the Congressional Budget Office has prepared the attached cost estimate for Title II of H.R. 4961, the Miscellaneous Revenue Act of 1981.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

RAY SCHEPPACH
(For Alice M. Rivlin, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: Title II of H.R. 4961.
2. Bill title: The Miscellaneous Revenue Act of 1981.
3. Bill status: As ordered reported by the House Committee on Ways and Means on December 9, 1981.
4. Bill purpose: Title II of H.R. 4961 would modify the Federal-State unemployment compensation program by amending certain provisions of the Social Security Act and the Federal Unemployment Tax Act (FUTA). More specifically, it would extend the Reed Act, exclude wages paid to student interns and to certain alien farmworkers from FUTA, and repeal those changes made by the 1981 Reconciliation Act to the unemployment compensation program for ex-service-members (UCX) while imposing new eligibility restrictions upon the program's claimants. The bill would also alter the Supplemental Security Income (SSI) program by substituting a prospective accounting period for the retrospective period contained in current law and clarifying recently enacted provisions relating to unnegotiated SSI checks. The bill also would change the Child Support Enforcement program (CSE) by reversing certain modifications mandated by the 1981 Reconciliation Act in regard to fee systems. Finally, the bill would effect certain technical amendments to the social services program.
5. Cost estimate: The section in this bill relating to the UCX program would result in additional future liabilities through an extension of existing entitlements that would require subsequent appropriation action to provide the necessary budget authority. The figures shown as "Required Budget Authority" represent an estimate of the additional budget authority needed to cover the estimated outlays that would result from enactment of H.R. 4961.

The sections in this bill relating to the SSI program would reduce future federal liabilities through a change to an existing entitlement and therefore could permit subsequent appropriations action to reduce the budget authority for this program. The figures shown as "Required Budget Authority" represent that amount by which budget authority for the SSI program could be reduced, as a result of this bill below the level needed under current law.

BUDGET AUTHORITY AND OUTLAY ESTIMATES FOR TITLE II OF H.R. 4961

[In millions of dollars]

Item	Fiscal year—				
	1982	1983	1984	1985	1986
<i>Reed Act Extension</i>					
Required budget authority-----					
Estimated outlays-----					
<i>Removal of Age Limitation for Exclusion from</i>					
<i>FUTA of Wages Paid To Student Interns</i>					
Revenue and budget authority-----	(*)	(*)	(*)	(*)	(*)
Estimated outlays-----					
<i>Extension of Exclusion from FUTA of Wages</i>					
<i>Paid to Certain Aliens, Farmworkers</i>					
Revenue and budget authority-----	-1	-1			
Estimated outlays-----					
<i>UCX Restructuring</i>					
Required budget authority-----	51	76	69	65	62
Estimated outlays-----	51	76	69	65	62
<i>Change to Prospective Accounting Period for SSI</i>					
Required budget authority-----	-69	-23	-19	-11	-9
Estimated outlays-----	-69	-23	-19	-11	-9
<i>Clarification of Provisions Governing Negotiability of SSI Checks</i>					
Required budget authority-----	(*)	(*)	(*)	(*)	(*)
Estimated outlays-----	(*)	(*)	(*)	(*)	(*)
<i>Child Support Enforcement Fee</i>					
Required budget authority-----					
Estimated outlays-----					
<i>CSE Technical Amendments</i>					
Required budget authority-----					
Estimated outlays-----					
<i>Social Services Technical Amendments</i>					
Required budget authority-----					
Estimated outlays-----					
<i>Total</i>					
Revenue and budget authority-----	-1	-1			
Required budget authority-----	-18	53	50	54	53
Estimated outlays-----	-18	53	50	54	53

* Less than \$500,000.

NOTE.—The costs of this bill fall within budget function 600.

Change to Prospective Accounting Period for SSI

The 1981 Reconciliation Act provided for SSI benefits to be calculated on a monthly retrospective accounting system. The new language would mandate a monthly prospective accounting system to avoid having SSI rates increased for inflation two months before the corresponding increases in social security benefits would be reflected in the countable income of dual SSI and social security recipients.

This estimate assumes that 93 percent of the income received by all SSI beneficiaries is made up of social security or other indexed federal benefits, based on agency data. The above savings are offset by \$30 million and \$46 million in annual benefit and administrative costs, respectively, that would have been saved by retrospective accounting due to lower benefit error rates. The benefit errors here would primarily result from changes in living arrangements rather than in income.

Clarification of Provisions Governing Negotiability of SSI Checks

This provision clarifies the reconciliation provisions establishing a process for dealing with unnegotiated SSI checks by specifying that the provisions apply to "State supplement-only checks" as well as SSI/State supplement checks.

The impact of this provision is estimated to be less than \$500,000.

Child Support Enforcement Fee

Prior to the Omnibus Budget Reconciliation Act of 1981, states could charge a \$20 application fee plus an additional fee to cover other administrative costs. The Omnibus Budget Reconciliation Act mandates a 10 percent fee to cover the cost of collection and other services for non-AFDC families. No part of the fee, however, could reduce support owed.

This amendment would permit states to continue their fee systems used prior to the Omnibus Budget Reconciliation Act of 1981. In addition, the states could, at their option, add an additional fee to be imposed on the absent parent.

This cost estimate assumes that the states would, under this amendment, collect approximately \$6 million in fees that would have been lost under the reconciliation provision. Since the federal government finances 75 percent of child support enforcement administrative costs, the federal savings from these fees will equal about \$4 million. There could be an offsetting cost if states do not impose or impose more slowly the additional fees mandated in the Reconciliation Act but made optional in this amendment. While it is very difficult to estimate these offsetting costs, this estimate assumes the costs offset the savings.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Charles Seagrave, Richard Hendrix, Kathleen Shepherd.

10. Estimate approved by:

C. G. NUCKOLS
(For James L. Blum,
Assistant Director for Budget Analysis).

PROVISIONS OF STATE LAWS

SEC. 303. (a) * * *

* * * * *

(e) (1) * * *

(2) (A) The State agency charged with the administration of the State law—

(i) shall require each new applicant for unemployment compensation to disclose whether or not such applicant owes child support obligations (as defined in the last sentence of [this subsection] *paragraph (1)*),

(ii) shall notify the State or local child support enforcement agency enforcing such obligations, if any applicant discloses under clause (i) that he owes child support obligations and he is determined to be eligible for unemployment compensation, that such applicant has been so determined to be eligible,

(iii) shall deduct and withhold from any unemployment compensation otherwise payable to an individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State agency under section 454[(20)] (19) (B) (i) of this Act, or

(III) any amount otherwise required to be so deducted and withheld from such employment compensation through legal process (as defined in section 462(e)). and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State or local child support enforcement agency,

Any amount deducted and withheld under clause (iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by such individual to the State or local child support enforcement agency in satisfaction of his child support obligations.

(B) For purposes of this paragraph, the term “unemployment compensation” means any compensation payable under the State law (including amounts payable pursuant to agreements under any Federal unemployment compensation law).

(C) Each State or local child support enforcement agency shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by such State agency under this paragraph which are attributable to child support obligations being enforced by the State or local child support enforcement agency.

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * *

PART D—CHILD SUPPORT AND ESTABLISHMENT OF PATERNITY

* * * * *

DUTIES OF THE SECRETARY

SEC. 452. (a) * * *

(b) The Secretary shall, upon the request of any State having in effect a State plan approved under this part, **[certify the amount of any child support obligation assigned to such State, including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A, (or undertaken to be collected by such State pursuant to section 454 (6)) to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954]** *certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954 the amount of any child support obligation (including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A) which is assigned to such State or is undertaken to be collected by such State pursuant to section 454(6).* No amount may be certified for collection under this subsection except the amount of the delinquency under a court or administrative order for support and upon a showing by the State that such State has made diligent and reasonable efforts to collect such amounts utilizing its own collection mechanisms, and upon an agreement that the State will reimburse the Secretary of the Treasury for any costs involved in making the collection. All reimbursements shall be credited to the appropriation accounts which bore all or part of the costs involved in making the collections. The Secretary after consultation with the Secretary of the Treasury may, by regulation, establish criteria for accepting amounts for collection and for making certification under this subsection including imposing such limitations on the frequency of making such certifications under this subsection.

* * * * *

STATE PLAN FOR CHILD AND SPOUSAL SUPPORT

SEC. 454. A State plan for child support must—

(1) * * *

* * * * *

(6) provide that (A) the child support collection or paternity determination services established under the plan shall be made available to any individual not otherwise eligible for such services upon application filed by such individual with the State, *including, at the option of the State, support collection services for the spouse (or former spouse) with whom the absent parent's child is living (but only if a support obligation has been established with respect to such spouse),* (B) an application fee for furnishing **[services under the State plan (other than collection of support)]** *such services* may be imposed, except that the amount of any such

application fee shall be reasonable, as determined under regulations of the Secretary, and [(C) the State will retain, but only if it is the State which makes the collection, the fee imposed under State law as required under paragraph (19);] (C) *any costs in excess of the fee so imposed may be collected from such individual by deducting such costs from the amount of any recovery made, or, at the option of the State, from the parent who owes the child or spousal support obligation involved;*

* * * * *

(18) provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 464, and take all steps necessary to implement and utilize such procedures; and

[(19) provide that a fee shall be imposed on the individual who owes a child or spousal support obligation in accordance with State law, with respect to all such child and spousal support obligations for which collection is made by the State agency under this part on behalf of an individual not otherwise eligible for collection services (as determined for purposes of paragraph (6)) in an amount equal to 10 percent of the amount so owed (and for purposes of this part, no part of the amount collected shall be considered to be a fee collected except amounts which exceed the actual amount of support owed); and]

[(20)](19) provide that the agency administering the plan—

(A) shall determine on a periodic basis, from information supplied pursuant to section 508 of the Unemployment Compensation Amendments of 1976, whether any individuals receiving compensation under the State's unemployment compensation law (including amounts payable pursuant to any agreement under any Federal unemployment compensation law) owe child support obligations which are being enforced by such agency, and

(B) shall enforce any such child support obligations which are owed by such an individual but are not being met—

(i) through an agreement with such individual to have specified amounts withheld from compensation otherwise payable to such individual and by submitting a copy of any such agreement to the State agency administering the unemployment compensation law, or

(ii) in the absence of such an agreement, by bringing legal process (as defined in section 462(e) of this Act) to require the withholding of amounts from such compensation.

* * * * *

TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY

* * * * *

AMOUNTS TRANSFERRED TO STATE ACCOUNTS

In General

Section 903. (a) * * *

* * * * *

Use of Transferred Amounts

(c) (1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with respect to their unemployment, exclusive of expenses of administration.

(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

(A) the purposes and amounts were specified in the law making the appropriation,

(B) the appropriation law did not authorize the obligation of such money after the close of the two-year period which began on the date of enactment of the appropriation law,

(C) the money is withdrawn and the expenses are incurred after such date of enactment, and

(D) the appropriation law limits the total amount which may be obligated during a twelve-month period (as prescribed in the law of the State), or during a transitional period of less than twelve months caused by a change in the twelve-month period (as prescribed in the law of the State), to an amount which does not exceed the amount by which (i) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b) during such twelve-month period or transitional period of less than twelve months and the [twenty-four] *thirty-four* preceding twelve-month periods (including the transitional period of less than twelve months if it is within such [twenty-four] *thirty-four* twelve-month periods) exceeds (ii) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State during such [twenty-four] *thirty-four* twelve-month periods (and the transitional period of less than twelve months if it is within the [twenty-four] *thirty-four* twelve-month periods).

For the purposes of subparagraph (D), amounts used by a State during any twelve-month period or transitional period of less than twelve months shall be charged against equivalent amounts which were transferred and which have not previously been so charged; except that no amount obligated for administration during any such period may be charged against any amount transferred during a twelve-month period or transitional period of less than twelve months earlier than the [twenty-fourth] *thirty-fourth* preceding twelve-month period (including the transitional period of less than twelve months if it is within such twenty-four twelve-month periods).

(3) (A) *If—*

(i) *amounts transferred to the account of a State pursuant to subsections (a) and (b) of this section were used in payment of unemployment benefits to individuals, and*

(ii) *the Governor of such State submits a request to the Secretary of Labor that such amounts be restored under this paragraph, then the amounts described in clause (i) shall be restored to the status of funds transferred under subsections (a) and (b) of this section which have not been used by eliminating any charge against amounts so transferred for use of such amounts in the payment of unemployment benefits.*

(B) *Subparagraph (A) shall apply only to the extent that the amounts described in clause (i) of such subparagraph do not exceed the amount then in the State's account.*

(C) *Subparagraph (A) shall not apply if the State has a balance of advances made to its account under title XII of this Act.*

(D) *If the Secretary of Labor determines that the requirements of this paragraph are met with respect to any request, the Secretary shall notify the Governor of the State that such requirements are met with respect to such request and the amount restored under this paragraph. Such restoration shall be as of the first day of the first month following the month in which the notification is made.*

* * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term “State”, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in title V and in part B of the title also includes [American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands] *Guam, and the Northern Mariana Islands*. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title XIX also includes the Northern Mariana Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term “States” when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. Such term when used in title XX also includes the Virgin Islands, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

* * * * *

LIMITATIONS ON PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS,
AND GUAM

SEC. 1108. (a) The total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, and under parts A and E of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

- (1) for payment to Puerto Rico shall not exceed—
 - (A) \$12,500,000 with respect to the fiscal year 1968,
 - (B) \$15,000,000 with respect to the fiscal year 1969,
 - (C) \$18,000,000 with respect to the fiscal year 1970,
 - (D) \$21,000,000 with respect to the fiscal year 1971,
 - (E) \$24,000,000 with respect to each of the fiscal years 1972 through 1978, or
 - (F) \$72,000,000 with respect to the fiscal year 1979 and each fiscal year thereafter;
- (2) for payment to the Virgin Islands shall not exceed—
 - (A) \$425,000 with respect to the fiscal year 1968,
 - (B) \$500,000 with respect to the fiscal year 1969,
 - (C) \$600,000 with respect to the fiscal year 1970,
 - (D) \$700,000 with respect to the fiscal year 1971,
 - (E) \$800,000 with respect to each of the fiscal years 1972 through 1978, or
 - (F) \$2,400,000 with respect to the fiscal year 1979 and each fiscal year thereafter;
- (3) for payment to Guam shall not exceed—
 - (A) \$575,000 with respect to the fiscal year 1968,
 - (B) \$690,000 with respect to the fiscal year 1969,
 - (C) \$825,000 with respect to the fiscal year 1970,
 - (D) \$960,000 with respect to the fiscal year 1971,
 - (E) \$1,100,000 with respect to each of the fiscal years 1972 through 1978, or
 - (F) \$3,300,000 with respect to the fiscal year 1979 and each fiscal year thereafter.

Each jurisdiction specified in this subsection may use in its program under title XX any sums available to it under this subsection which are not needed to carry out the programs specified in this subsection.

* * * * *

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR
THE AGED, BLIND, AND DISABLED

* * * * *

PART A—DETERMINATION OF BENEFITS

ELIGIBILITY FOR AND AMOUNT OF BENEFITS

Definition of Eligible Individual

SEC. 1611. (a) * * *

* * * * *

Period for Determination of Benefits

[(c) (1) An individual's eligibility for benefits under this title and the amount of such benefits shall be determined for each quarter of a calendar year except that, if the initial application for benefits is filed in the second or third month of a calendar quarter, such determinations shall be made for each month in such quarter. Eligibility for and the amount of such benefits for any quarter shall be redetermined at such time or times as may be provided by the Secretary.]

(c) (1) An individual's eligibility for a benefit under this title for any month, and the amount of such benefit, shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

* * * * *

PART B—PROCEDURAL AND GENERAL PROVISIONS

PAYMENTS AND PROCEDURES

Payments of Benefits

SEC. 1631. (a) * * *

* * * * *

Payment to States With Respect to Certain Unnegotiated Checks

(i) (1) The Secretary of the Treasury shall, on a monthly basis, notify the Secretary of all benefit checks issued under this title which include amounts representing State supplementary payments as described in paragraph (2) and which have not been presented for payment within one hundred and eighty days after the day on which they were issued.

(2) The Secretary shall from time to time determine the amount representing the total of the State supplementary payments made pursuant to agreements under section 1616(a) of this Act and under section 212(b) of Public Law 93-66 which is [included in all checks payable to individuals entitled to benefits under this title but] *included in all such benefit checks* not presented for payment within one hundred and eighty days after the day on which they were issued, and shall pay each State (or credit each State with) an amount equal to that State's share of all such amount. Amounts not paid to the States shall be returned to the appropriation from which they were originally paid.

* * * * *

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

* * * * *

ALLOTMENTS

SEC. 2003. (a) * * *

(b) The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

(1) the amount specified in subsection (c), reduced by

(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a),

as the population of that State bears to the population of all the States (*other than Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands*) as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated (subject to subsection (d)) prior to the first day of the third month of the preceding fiscal year.

* * * * *

SECTION 8521 OF TITLE 5, UNITED STATES CODE

SUBCHAPTER II—EX-SERVICEMEN

§ 8521. Definitions; application

(a) For the purpose of this subchapter—

(1) “Federal service” means active service, including active duty for training purposes, in the armed forces which either began after January 31, 1955, or terminated after October 27, 1958, if—

(A) that service was continuous for [365] 730 days or more, or was terminated earlier because of an actual service-incurred injury or disability; and

[(B) with respect to that service, the individual—

[(i) was discharged or released under honorable conditions;

[(ii) did not resign or voluntarily leave the service; and

[(iii) was not released or discharged for cause as defined by the Department of Defense;]

(B) *with respect to that service, the individual—*

(i) was discharged or released under conditions other than dishonorable; and

(ii) was not given a bad conduct discharge or, if an officer, did not resign for the good of the service;

* * * * *

(c) (1) *An individual shall not be entitled to compensation under this subchapter for any week before the fifth week beginning after the week in which the individual was discharged or released.*

(2) *The aggregate amount of compensation payable under this subchapter to any individual with respect to any benefit year shall not exceed 13 times the individual's weekly benefit amount for total unemployment.*

OMNIBUS BUDGET RECONCILIATION ACT OF 1981

* * * * *

**TITLE XXIII—PUBLIC ASSISTANCE
PROGRAMS****Subtitle A—Aid to Families With Dependent Children;
Child Support Enforcement**

* * * * *

CHAPTER 2—CHILD SUPPORT ENFORCEMENT

* * * * *

COST OF COLLECTION AND OTHER SERVICES FOR NON-AFDC FAMILIES**SEC. 2333.(a) * * ***

* * * * *

(c) Section ~~453~~⁴⁵³(a) of such Act is amended by adding at the end thereof the following new sentence: "In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part."

* * * * *

Subtitle B—Supplemental Security Income Benefits**RETROSPECTIVE ACCOUNTING**

SEC. 2341. [(a) Section 1611(c) of the Social Security Act is amended to read as follows:

["(c) (1) An individual's eligibility for a benefit under this title for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraph (2), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

["(2) The amount of such benefit for the month in which application for such benefits is filed or, if the Secretary so determines, for such month and the following month, and for any month following a month of ineligibility for such benefits (or, if the Secretary so determines, such month and the following month) shall be determined on the basis of the individual's (and eligible spouse's, if any) income and other relevant circumstances in such month.

["(3) For purposes of this subsection, an application shall be effective as of the first day of the month in which it is filed.

["(4) The Secretary may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Secretary shall apply, to the month preceding the month of removal, or, if the Secretary so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.".]

* * * * *

[(c) (1) The amendments made by this section shall be effective with respect to months after the first calendar quarter which ends more than five months after the month in which this Act is enacted.

[(2) The Secretary of Health and Human Services may, under conditions determined by him to be necessary and appropriate, make a transitional payment or payments during the first two months for which the amendments made by this section are effective. A transitional payment made under this section shall be deemed to be a payment of supplemental security income benefits.]

* * * * *

Subtitle C—Block Grants for Social Services

* * * * *

CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 2353. (a)(1) Section 3(a) of the Social Security Act is amended—

* * * * *

[(r) Section 471(a)(10) of such Act is amended by striking out "standards referred to in section 2003(d)(1)(F)" and inserting in lieu thereof "standards in effect in the State with respect to child day care services under title XX".]

(r) Section 471(a)(10) of such Act is amended to read as follows:

"(10) provides for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admissions policies, safety, sanitation, and protection of civil rights, and provides that the standards so established shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B of this title;"

* * * * *

97TH CONGRESS }
2d Session }

SENATE

{ REPT. 97-494
Vol. 1 }

**TAX EQUITY AND FISCAL RESPONSIBILITY
ACT OF 1982**

R E P O R T

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

H.R. 4961

together with

ADDITIONAL SUPPLEMENTAL AND MINORITY VIEWS



JULY 12, 1982.—Ordered to be printed

**U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1982**

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(II)

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TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

JULY 12, 1982.—Ordered to be printed

Mr. DOLE, from the Committee on Finance,
submitted the following

REPORT

together with

ADDITIONAL SUPPLEMENTAL AND MINORITY VIEWS

[To accompany H.R. 4961]

The Committee on Finance, to which was referred the bill (H.R. 4961) to make miscellaneous changes in the tax laws, having considered the same, reports favorably thereon with amendments and an amendment to the title and recommends that the bill as amended do pass.

(1)

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FINANCE COMMITTEE RECOMMENDATIONS—SUMMARY TABLE OF COST SAVINGS

[Outlays in millions of dollars]

Provision	Fiscal year—			3-year total
	1983	1984	1985	
Medicare:				
Delay initial eligibility.....	170	230	270	670
Working aged.....	350	530	600	1,480
Home health copayments.....	35	65	75	175
Radiology and pathology reim- bursement.....	160	210	250	620
Part B deductible.....	65	155	255	475
Limitation on economic index.....	230	390	460	1,080
Repeal nursing differential.....	95	110	125	330
Payments to provider-based physi- cians.....	63	73	84	220
Part B premium.....	36	204	499	739
223 limits on total costs and limit rate of increase in Medicare revenues.....	610	1,720	3,120	5,450
Regulations:				
Eliminate private room subsidy.....	54	75	80	209
SNF and HHA services.....	18	46	46	110
Duplicate payments for out- patient services.....	160	225	270	655
Provider cost report audits.....	130	300	300	730
Periodic interim payment.....	750	100	-870	-20
Assistants at surgery.....	55	130	150	335
Judicial review.....	0	0	0	0
Ineffective drugs.....	0	0	0	0
Payments to HMO's.....	0	0	0	0
Medicare subtotal.....	2,981	4,563	5,714	13,258
Medicaid:				
Allow States to require nominal co- payments.....	42	47	53	142
Eliminate matching for medicare Part B buy-in.....	203	216	230	649
Allow States to apply liens.....	183	200	221	604
Reduce error rate tolerance.....	30	65	72	167
Medicare changes.....	30	80	140	250
AFDC changes.....	100	130	170	400
Medicaid subtotal.....	588	738	886	2,212
Utilization and Quality Control Peer Review:				
Peer review.....	15	15	20	50
Health subtotal.....	3,584	5,316	6,620	15,520

FINANCE COMMITTEE RECOMMENDATIONS—SUMMARY TABLE OF COST SAVINGS—Continued

[Outlays in millions of dollars]

Provision	Fiscal year—			3-year total
	1983	1984	1985	
AFDC:				
Round benefits.....	9	10	10	29
Prorate 1st month's benefit.....	13	14	14	41
Eliminate uniformed service as reason for AFDC.....	15	17	17	49
Refusal to work.....	1	1	1	3
Mandatory job search.....	20	50	50	120
End parent benefit when child is 16.	47	48	48	143
Include all minor children (except SSI).....	63	64	64	191
Count income of unrelated adults..	69	70	70	209
Repeal emergency assistance.....	60	60	60	180
Prorating for shelter and utilities...	43	44	45	132
Reduce error rate match.....	85	129	41	255
AFDC receipt by minor children.....	25	27	29	81
Retrospective accounting.....				
Reopen WIN demonstration authority.....				
AFDC subtotal.....	450	534	449	1,433
Child support enforcement:				
Modified collection fee for non-AFDC cases.....	12	16	11	39
Child support allotments for Armed Forces.....	7	9	10	26
Reimbursement of State agency....	3	4	4	11
CSE subtotal.....	22	29	25	76
Supplemental security income:				
Prorate 1st month's benefit.....	26	28	32	86
Round benefits.....	20	25	30	75
COLA coordination.....	45	41	43	129
Hold harmless phaseout.....	30	37	45	112
Recovery of overpayments.....	16	17	18	51
SSI subtotal.....	137	148	168	453
Unemployment compensation:				
Round benefits.....	0	10	19	29
Unemployment compensation subtotal.....	0	10	19	29
Grand total.....	4,193	6,037	7,281	17,511

II. Summary of Spending Reduction Provisions

A. Medicare Provisions

Delay initial eligibility date for Medicare entitlement.—The initial eligibility date would be delayed from the first day of the month in which the individual turns 65 to the first day of the following month.

Modify coverage of the working aged.—Employers would be required to offer employees aged 65 through age 69 the same health benefit plan offered to younger workers and Medicare would be a secondary payor to these plans.

Require minimal copayments on home health services under Medicare.—Home health services would be subject to copayments equal to 5 percent of the average reasonable cost per visit.

Reimburse inpatient radiology and pathology services at 80 percent of reasonable charges.—The special 100 percent reimbursement rate for inpatient radiology and pathology services would be eliminated. Such services would be paid for on the same basis as other physicians' services.

Index part B deductible to the Consumer Price Index (CPI).—The Part B deductible would be indexed to the CPI beginning in 1983. As a result the deductible is estimated to be \$80 in 1983, \$85 in 1984, and \$89 in 1985.

Provide for no increase in physician fee economic index.—No increase would be allowed in the economic index for fiscal year 1983 and only a 5-percent increase will be permitted in fiscal year 1984.

Repeal routine nursing salary cost differential.—The differential factor paid to hospitals and skilled nursing facilities for inpatient routine nursing salary costs would be eliminated.

Payments for services of provider-based physicians.—The Secretary of HHS would be directed to prescribe regulations which would distinguish between the services of hospital-based physicians which are covered under Medicare on a reasonable cost basis and those which are reimbursable on the basis of reasonable charges; and establish standards of reasonableness to be applied in each case.

Hold part B premium constant as a percentage of program costs.—The part B premium paid by enrollees in the Supplementary Medical Insurance program would be set and maintained at 25 percent of part B program costs.

Limit Medicare reimbursement to hospitals.—The current limits on Medicare reimbursement to hospitals (i.e., the section 223 limits) would be extended and modified to include ancillary operating costs and special care unit operating costs; annual increases in the overall operating costs per case would be limited (for a period of not more than 3 years); and the Secretary of HHS would be directed to develop methods under which hospitals, skilled nursing facilities and other providers could be paid on a prospective basis.

Require certain Medicare regulations.—The Secretary of HHS would be required to issue regulations to (a) eliminate the private room subsidy for hospitals, (b) establish single reimbursement limits for skilled nursing facility and home health agency services, and (c) eliminate duplicate overhead payments for outpatient services.

Audit and medical claims review.—The Medicare contracting budget for fiscal years 1983, 1984, and 1985 would be supplemented by \$45 million in each year to be spent specifically for audit and medical review activities.

Temporarily delay the periodic interim payment (PIP).—Periodic interim payments to hospitals for the latter part of September 1983 would be delayed until October 1983. There would be a similar deferral of PIP payments from September to October of 1984.

Assistants at surgery.—Reimbursement for assistants at surgery in hospitals where a training program exists in that specialty would be prohibited, except in the case of exceptional circumstances.

Judicial district in which providers may obtain judicial review.—Federal judicial review of an adverse decision of the Provider Reimbursement Review Board involving actions brought jointly by several providers of Medicare services could be conducted by the U.S. District Court for the district where the "principal party" for the group is located.

Ineffective drug provision.—Payments under Medicare Part B and under Medicaid for ineffective drugs would be prohibited.

Medicare payments to HMO's.—Current requirements for contracting with health maintenance organizations (HMO's) would be modified by authorizing prospective reimbursement under risk sharing contracts with competitive medical plans (CMP's) at a rate equal to 95 percent of the Adjusted Average Per Capita Cost (AAPCC).

Technical corrections to Omnibus Budget Reconciliation Act of 1981.

B. Medicaid Provisions

Allow nominal Medicaid copayments.—The prohibition against nominal copayments for mandatory services to categorically eligible medicaid recipients would be repealed except in the case of certain inpatient hospital and ambulatory services for children and pregnant women and for services provided to inpatients in medical institutions who are required to spend, except for a personal needs allowance, all their income for medical expenses.

Eliminate matching for Medicare Part B "buy-in".—Federal matching for Part B premium payments for Medicaid recipients would be eliminated.

Modify lien provision.—States would be permitted under certain circumstances to attach the real property of Medicaid recipients who are permanently institutionalized in nursing homes or other long-term care medical institutions.

Reduce Medicaid error rates.—States would be required to reduce their Medicaid error rates to 3 percent.

Continuation of Medicaid eligibility.—States would be allowed the option of continuing Medicaid coverage for certain working families who were made ineligible for AFDC as a result of certain provisions of the 1981 Reconciliation Act.

Technical corrections to Omnibus Budget Reconciliation Act.

C. Utilization and Quality Control Peer Review

Contract for utilization and quality control peer review.—The Professional Standards Review Organizations (PSRO) program, would be repealed. The Secretary would be required to enter into contracts with peer review organizations for an initial period of 2 years, renewable biannually, for the purpose of promoting effective, efficient, and economical delivery of health care under Medicare.

D. Aid to Families With Dependent Children (AFDC) Provisions

Rounding of eligibility and benefit amounts.—States would be required to round both their need standards and actual monthly benefit amounts to the next lower whole dollar.

Proration of first month's benefit.—Therefor the monthly application AFDC benefit would be prorated from the date of application.

Eliminate uniformed service as basis for AFDC eligibility.—Absence from the home solely because of uniformed service would be excluded as a basis for AFDC eligibility.

Refusal to work.—Sanctions would be imposed on individuals who refuse work, reduce hours of employment, or terminate employment, without good cause.

Mandatory job search.—Individuals applying for AFDC benefits would be required to participate in job search while the application is pending. Continued job search would be required, after the application becomes effective, for not more than a total of 8 weeks each year.

Inclusion and exclusion of specified individuals' needs and income.—The Federal statute would define those individuals whose needs and incomes must be included or excluded from the AFDC filing unit: (1) the employable parent's benefit would end when the youngest child reaches age 16; (2) all children would be included in the filing unit (except SSI disabled children and stepbrothers and stepsisters); and (3) the income of unrelated persons living in the AFDC household would be counted as available to the AFDC family.

Repeal of emergency assistance program.—The emergency assistance program would be repealed.

Proration for shelter and utilities.—States would be allowed to prorate the portion of the AFDC grant for shelter and utilities for AFDC families living in households with other individuals.

Reduction of Federal match for payment errors.—The allowable error rate for AFDC would be 4 percent in fiscal year 1983, 3 percent in fiscal year 1984, and 3 percent in fiscal year 1985.

Households headed by minor parents.—To receive AFDC benefits, a minor parent and her child would have to reside in the home of the minor parent's own parent or guardian.

Exclusion from income of certain State payments.—States would be allowed to exclude from calculations of AFDC benefit amounts any payments made solely from State funds that are designed to compensate for lost income in the period before the new benefit amount can be calculated and paid.

Extension of time for States to establish a work incentive demonstration program.—States would be allowed two additional years in which to exercise their option to operate a WIN demonstration program (as provided in the 1981 Reconciliation Act).

E. Child Support Enforcement Provisions

Fee for services to non-AFDC families.—The law in effect prior to P.L. 97-35 would be restored which allows States to charge a reasonable fee for a non-AFDC collection and retain from the amount collected an amount equal to administrative costs not covered by the fee. As a State option, authority would be retained for States to collect from the parent who owes child or spousal support an amount to cover administrative costs, in addition to the child support payment.

Allotments from pay for child and spousal support owed by members of the uniformed services on active duty.—Allotments would be required from the pay and allowances of any member of the uniformed service, on active duty, when he fails to make child (or child and spousal) support payments.

Reimbursement of State agency in initial month of ineligibility for AFDC.—States would be permitted to reimburse themselves for AFDC that would have already been paid for months before the support was collected and known to make the family ineligible. Thus, the family would not receive double payment for the same month, both in the form of AFDC and through receipt of the support collection.

F. Supplemental Security Income Provisions

Prorate first month's benefit based upon date of application.—The first month's SSI benefit would be prorated from the date of application or the date of eligibility, whichever is later.

Round SSI eligibility and benefit amounts.—SSI monthly benefit and income eligibility amounts would be rounded to the next lower dollar. Rounding would take place after the cost of living adjustment had been made.

Coordination of SSI and OASDI cost-of-living adjustments.—The SSI and social security (OASDI) benefit increases would be coordinated so that at the time the cost-of-living adjustment is made, the recipient's SSI benefit would be based on his or her social security payment in the same month. Also, whenever the Secretary judges there to be reliable information on the recipient's income or resources in a given month, the SSI benefit in that month would be based on that information.

Phase out "hold harmless" protection.—Federal hold harmless payments would continue to be phased out, being reduced to 40 percent of what they would otherwise be in 1983, to 20 percent in 1984, with no "hold harmless" payments made in 1985 and future years.

Recovery of SSI overpayments.—The Secretary would be authorized to collect SSI overpayments from benefits payable under other programs administered by the Social Security Administration (Black Lung and OASDI benefits).

G. Unemployment Compensation Provisions

Round unemployment benefits to next lowest dollar.—The Federal 50 percent matching share of extended unemployment benefits would not be available on that part of extended unemployment benefit payments which result from a failure on the part of the State to have a benefit structure in which benefits are rounded down to the next lower dollar.

III. Description of Spending Reduction Provisions

A. PROVISIONS RELATED TO MEDICARE

DELAY INITIAL ELIGIBILITY DATE FOR MEDICARE ENTITLEMENT

(Section 101 of the Bill)

Present law.—Under current law, eligibility for Medicare begins on the first day of the month in which an individual reaches age 65. As a result, medicare often pays benefits for services that were provided before an individual reaches his 65th birthday.

Committee amendment.—The amendment defers eligibility for parts A and B of Medicare until the first day of the month following the month the individual attains age 65.

The committee believes that this amendment will not disrupt current health benefits coverage for the large majority of people, although some gaps may occur. The committee notes that some individuals may now be covered by health insurance policies in which coverage under such contracts terminates upon reaching age 65 or on the first day of the month in which they attain such age. The committee is concerned that such persons could find themselves with gaps in protection as a result of the provision to delay medicare coverage until the beginning of the month after reaching age 65. However, the committee believes that State insurance authorities, which are the responsible governmental authorities for regulating private insurance contract provisions, will take such steps as may be necessary to assure that private policies will be amended or adjusted to assure continuity of coverage under such plans until Medicare coverage begins. However, the committee notes that medicaid coverage will continue to be available to certain needy aged individuals during the brief period before their medicare coverage begins.

The committee directs the Secretary of HHS to make all reasonable efforts to inform individuals in advance of the date their medicare coverage begins, and, to the extent feasible, make sure that these people do not suffer undue hardships as a result of the deferral of medicare eligibility.

Effective date.—To be applied to individuals who attain age 65 after August 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$170
1984.....	230
1985.....	270

COORDINATION OF MEDICARE BENEFITS WITH REQUIRED HEALTH BENEFITS
FOR EMPLOYEES AGE 65 TO 70

(Section 102 of the Bill)

Present law.—The Federal Age Discrimination in Employment Act (ADEA) prohibits employment bias on the basis of age between 40 and 70 for most workers in the private sector. However, the ADEA regulations permit an employer to “carve-out” from his health plan those benefits that are actually paid for by medicare. The employer’s plan pays only for those expenses it insures against that are not paid for under the Government’s program. As an alternative, an employer can offer employees eligible for medicare a separate plan that supplements medicare. However, the employer must assure: (1) that the costs of such a plan are not less than what would be expended to include such individuals in the regular employer plan with medicare “carve-out”, and (2) that the supplemental plan when taken in combination with medicare provides benefits that are not less favorable than an employee eligible for medicare would receive under the employer’s regular plan for other workers. The regulations further provide that if the employer’s regular plan requires no employee contribution or an amount less than that required for part B coverage under medicare, the employer must pay or contribute toward the part B contribution so as to make the total benefits available no less favorable for employees over 65 than for workers under 65.

Additionally, except in certain specified circumstances, present law provides that the Medicare program pays benefits to which covered individuals are entitled without regard to any other sources of payment to which such persons may also be entitled. Medicare, in other words, is the “primary” or first payor of benefits in dual coverage situations. Medicare is the “secondary” payor of benefits only in circumstances involving workmen’s compensation cases, in instances where payment can be made under an automobile or liability insurance policy or plan or under no-fault insurance, and where benefits are payable under an employer group health plan for services furnished to end-stage renal disease beneficiaries during a period of up to twelve months.

Committee amendment.—The committee amendment coordinates the benefits under the Medicare program with health benefits for employees (and their spouses) age 65 through age 69, in group health benefits plans sponsored by employers of 20 or more regular employees.

Under the amendment, Medicare’s payment for any item or service furnished to an employee (or his spouse), would be reduced where the combined payment under Medicare and the employer’s health benefits plan would otherwise exceed, (1) for items or services reimbursed on a cost or cost-related basis, their reasonable cost, or, (2) for items reimbursed on a charge basis, the higher of the reasonable charge (or other amount payable under Medicare, without regard to the program deductibles or coinsurance) or the amount payable under the employer

group plan (without regard to deductibles or coinsurance imposed under that plan). In no case would Medicare pay more than Medicare would have paid in the absence of any employer plan coverage.

The coordination of benefits provision would apply if payment has been made, or can reasonably be expected to be made (as determined by the Secretary in regulations), for any item or service on behalf of an employee who has reached the calendar month following the month in which he attains age 65, but is under age 70 (or on behalf of the spouse of the employee, if the spouse has reached the calendar month following the month in which the spouse attains age 65 and is under age 70). Coordination of benefits would only occur in the case of health benefits plans related to the employee's employment, and not in the case of any other health benefits to which the employee (or his spouse) may be entitled, individually or under some other group arrangement. The Secretary could waive the provisions of this amendment in the case of individual claims where he determines that the probability of recovery or the amounts involved do not warrant pursuing such claims. The committee expects that the Secretary will establish in regulations rules regarding minimum amounts recoverable and the procedures for seeking recovery from employer plans similar to those employed by Medicare in other instances where Medicare is the secondary payor.

The amendment would not apply in the case of any employer health benefits plan offered by employers employing less than 20 full-time employees (regardless of the number of employees and family members actually enrolled in the plan). The committee intends that the Secretary issue regulations prescribing the definition of a "full-time" employee and the methods to be used to determine whether or not this provision applies to specific employers and employer health benefit plans. The committee believes that changes in the primacy relationship between Medicare and employer-based plans should not extend to small businesses, which often employ many older workers as a significant part of their total work force. Increases in the fringe benefit costs of these employers could discourage them from continuing to hire or to retain older workers in their jobs.

The committee amendment amends the Age Discrimination in Employment Act by requiring an employer to offer his employees age 40 or over but under age 70 (and their dependents) the same health benefits offered the employer's younger employees (and their dependents). Employers must offer these benefits as primary to benefits under Medicare for employees (and their spouses) age 65 and over, but under age 70. While the employer must offer the coverage the employee may choose not to participate in the employers plan.

Effective date.—January 1, 1983.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$350
1984.....	530
1985.....	600

REQUIRE MINIMAL COPAYMENT ON HOME HEALTH SERVICES UNDER
MEDICARE

(Section 103 of the Bill)

Present law.—Under current law, an unlimited number of home health visits are covered without a deductible or coinsurance provided certain conditions are met. Public Law 96-499 eliminated the requirement, that home health services covered under part B be subject to the annual deductible. The law also removed the 100-visit limit under parts A and B on the number of home health visits that medicare will cover, and the requirements for prior hospitalization.

Committee amendment.—The amendment imposes a specified copayment amount (recalculated annually) for all home health visits. The uniform nationwide copayment amount is to be equal to five percent of the estimated average reasonable cost per visit rounded to the nearest dollar. The nationwide copayment amount for calendar year 1983 is estimated at \$2.00.

Prior to 1973 home health benefits payable under Part B of Medicare were subject to 20 percent coinsurance on the same basis as other Part B services. The Committee notes that the "Omnibus Reconciliation Act of 1980" (P.L. 96-499) significantly liberalized home health benefits under Medicare, by eliminating the limitation on the number of visits, deleting the prior hospitalization requirement, and eliminating the deductible for Part B benefits. The committee is concerned that there is currently no financial incentive for beneficiaries to use only needed services. The committee feels that the coinsurance charge imposed by this provision will provide this incentive while not imposing an unreasonable hardship on beneficiaries.

Effective date.—January 1, 1983.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$35
1984.....	65
1985.....	75

REIMBURSEMENT FOR SERVICES OF RADIOLOGISTS AND PATHOLOGISTS TO
HOSPITAL INPATIENTS AT 80 PERCENT OF REASONABLE CHARGES

(Section 104 of the Bill)

Present law.—Part B of Medicare will pay 100 percent of the reasonable charges of radiologists and pathologists who furnish radiology and pathology services to hospital inpatients, if such physicians accept assignment on all claims for such patients. Such services are not subject to the deductible or coinsurance features of the Part B program.

Committee amendment.—Medicare will ordinarily reimburse 80 percent of the reasonable charges for physician and most other part B services after enrollees satisfy an annual deductible. Beneficiaries are responsible for the remaining 20 percent of the reasonable charges, known as the coinsurance, and any other amounts that exceed reason-

able charges or which are for noncovered services. The committee amendment eliminates the special 100 percent reimbursement rate for inpatient services furnished by radiologists and pathologists who accept assignment in connection with claims for such services. Instead, Medicare would pay for such services on the same basis as other physicians services are now reimbursed, i.e., 80 percent of reasonable charges after the part B deductible has been met.

The 1967 Social Security Amendments modified the part B program to reimburse 100 percent of the reasonable charges for services furnished to hospital inpatients by physicians in the fields of radiology and pathology. This provision was intended to simplify reimbursement procedures and streamline claims processing by hospitals and intermediaries. It was also anticipated that combined billing by hospitals (on behalf of the physicians and the facilities) for radiological and pathological services would result in administrative savings both for those who used it and for the Medicare program. However, the 1967 change did not restrict the 100 percent payment feature only to radiologists and pathologists who billed through combined arrangements. During the 1970's, increasing numbers of such physicians billed patients directly on a fee-for-service basis. The Omnibus Reconciliation Act of 1980 further amended the special provisions relating to radiologists and pathologists by requiring these physicians to accept assignment as the quid pro quo for the waiver of the deductible and coinsurance features of the part B program.

Since the simplifications anticipated from combined billing arrangements have not materialized, and since the trend toward separate fee-for-service billing by radiologists and pathologists continues, there is no longer any justification for the special coinsurance exemption.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$160
1984.....	210
1985.....	250

INDEX PART B DEDUCTIBLE TO THE CONSUMER PRICE INDEX

(Section 105 of the Bill)

Present law.—Under Part B, beneficiaries are required to incur \$75 annually in expenses for most covered medical services before the program will begin making payments. Public Law 97-35 increased this deductible amount from \$60 (the level it had been at since 1973) to \$75 effective in calendar year 1982.

Committee amendment.—The amendment indexes the part B deductible to the Consumer Price Index (CPI) beginning in calendar year 1983. The deductible is to be equal to \$75 multiplied by the ratio of the CPI for all urban consumers (U.S. city average) for the preceding July to such CPI for July 1981 and rounded to the nearest dollar. As a result, the deductible is estimated to be \$80 in 1983, \$85 in 1984, \$89 in 1985. Indexing the Part B deductible as in the case of the Part A deductible, would preserve initial beneficiary liability

for medical services in real terms. Such indexing would more closely link the deductible amount to the increases in program costs.

Effective date.—With respect to deductibles beginning in calendar year 1983.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$65
1984.....	155
1985.....	255

PROVIDE FOR NO INCREASE IN PHYSICIAN FEE ECONOMIC INDEX

(Section 106 of the Bill)

Present law.—Under Medicare Part B, charges billed by physicians that are recognized for reimbursement purposes as “reasonable charges” are limited by customary and prevailing charge screens which are updated every July 1. As a result of legislation enacted in 1972 annual increases in prevailing charge screens cannot exceed annual increases in an economic index. The economic index reflects increases in input costs for physicians’ services and general earnings increases. The increase for the 12-month period beginning July 1, 1982 is 8.9 percent.

Committee amendment.—The amendment provides that the increase in the economic index effective July 1, 1982 would not be in effect for charges for services rendered on or after the effective date of the provision. The increase allowed for the 12-month period beginning July 1, 1983 could not exceed five percent. Physicians with customary charges below the new prevailing charge levels could have their reasonable charge increased up to the new prevailings.

Physician service fees rose by 11 percent in 1981. For this reason physicians must be expected to bear part of the burden of limits on program growth. The committee expects cost savings to be borne by institutions, physicians, and beneficiaries. The committee does not expect beneficiaries to increase their out-of-pocket expenses for medical services unless providers and physicians are also directly affected by the committee’s cost savings provisions.

Effective date.—Applicable to charges for services rendered on or after October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$230
1984.....	390
1985.....	460

REPEAL ROUTINE NURSING SALARY COST DIFFERENTIAL

(Section 107 of the Bill)

Present law.—By law, Medicare reimburses hospitals and skilled nursing facilities on the basis of their “reasonable costs.” Since July

1969, the Secretary has paid a plus factor for inpatient routine nursing salary costs on the theory that older patients require more nursing care than younger patients. This plus factor was initially 8½ percent. Public Law 97-35 reduced, effective October 1, 1981, the inpatient routine nursing salary cost differential to 5 percent with respect to hospital services.

Public Law 97-35 also directed the Comptroller General to study the extent (if any) to which the average cost of efficiently providing routine inpatient nursing care to Medicare beneficiaries exceeds the average cost of providing such care to other patients.

Committee amendment.—The amendment deletes the routine nursing salary cost differential paid to hospitals and SNF's effective October 1, 1982. The committee believes this differential is no longer necessary in view of the changes which have occurred since 1969 in the way services are furnished. For example, sicker patients have been shifted from general routine care areas to special care units (for which the more intensive nature of care is recognized in reimbursement calculations).

The General Accounting Office issued a report in January 1982 which reviewed the results of existing nursing differential studies. GAO stated that while the studies did not provide conclusive evidence for or against the existence of an industrywide differential, it believed that, on balance, evidence tended to be against its existence. The GAO stated that to obtain conclusive evidence it would need to conduct a work-sampling study in routine nursing care units in a nationwide sample of hospitals. The projected cost of such a study is \$8.3 million.

The committee does not feel, based on existing information, that there is a compelling reason for the differential. The amendment therefore provides for its repeal.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$95
1984.....	110
1985.....	125

PAYMENT FOR SERVICES OF PROVIDER BASED PHYSICIANS

(Section 108 of the Bill)

Present law.—Hospitals and skilled nursing facilities retain or employ various kinds of physicians, such as radiologists, anesthesiologists and pathologists, who provide numerous services for the institution itself in addition to direct patient care services. The services that these hospital-based physicians perform for the institution may include supervision of professional or technical personnel in certain hospital departments (e.g., laboratory or X-ray departments), research, teaching or administration. These practitioners negotiate a variety of financial agreements with hospitals and skilled nursing facilities regarding the services rendered by them in the provider setting.

Under current law and regulations, services furnished by a physician to hospital inpatients are reimbursed on the basis of reasonable charges

under part B only if such services are identifiable professional services to patients that require performance by physicians in person and which contribute to the diagnosis or treatment of individual patients. All other services performed for the hospital (or for a skilled nursing facility) by provider-based specialists (e.g., radiologists, anesthesiologists, pathologists) are to be reimbursed as provider services on the basis of reasonable costs.

Committee amendment.—While the above policy has been established by the law and by regulation since the inception of the medicare program, it has never been uniformly implemented. As a result the amounts that the program has paid to some hospital based physicians are related to the amount of work performed by hospital employees rather than by the physician himself.

The committee amendment directs the Secretary of Health and Human Services to prescribe regulations, effective no later than October 1, 1982, which will distinguish between (1) professional medical services which require performance of the physician in person and which are personally rendered to individual patients and which contribute to the patients' diagnosis and treatment and are reimbursable only under part B and (2) the professional medical services of practitioners which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. The Secretary would be expected to prescribe specific conditions, appropriate to each of the physician specialties, to establish when a practitioner's involvement in a patient care service is adequate to justify treating it as a physician service which is reimbursable on a reasonable charge basis under the part B program.

Medicare reimbursement for the services that would be covered under the respective parts of the program would be subject to appropriate tests of reasonableness.

As in the case of other physicians, services that are reimbursable on a reasonable charge basis will be subject to the customary-and-prevailing charge limits established under Part B of medicare. Similarly the compensation for supervision, teaching, administration and other professional services that would be reimbursable on a reasonable cost basis would be evaluated in terms of time that the physician expends, compensation comparability, and such other factors as the Secretary may prescribe.

The committee directs the Secretary to monitor changes in arrangements, patterns of service and hospital physician relationships as a result of this proposal.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$63
1984.....	73
1985.....	84

HOLD PART B PREMIUM CONSTANT AS A PERCENTAGE OF PROGRAM COSTS

(Section 109 of the Bill)

Present law.—Individuals who elect to be covered under the Supplementary Medical Insurance Program (part B), are required to pay a monthly premium. The amount of the premium which is set annually is \$12.20, effective July 1, 1982.

Prior to July 1973, the Secretary annually determined the premium rate by estimating the amount necessary to meet one-half of the benefits provided to the aged, the administrative costs payable from the part B trust fund for the applicable 12-month period, plus a contingency reserve. The Federal Government appropriated out of general revenues a contribution equal to the total of the premiums paid by the elderly to finance the remaining half of the Supplementary Medical Insurance program's costs. The Federal share was not limited to the amount paid by premiums—if the premium estimate was too low, Federal revenues made up the difference.

The "Social Security Amendments of 1972" (P.L. 92-603) and subsequent amendments modified the method by which premiums were calculated to limit increases in premium amounts to the percentage by which monthly cash benefits increased in the interval since the premium had been last increased. Under current law, the Secretary is required to calculate each December the premium amount for the aged, to be effective the following July. The new premium rate is the lower of: (a) an amount sufficient to cover one-half of the benefits for the aged plus administrative costs, and a contingency amount (i.e., the actuarial rate); or (b) the current premium amount increased by the percentage by which social security cash benefits increase during the period between May of the current year and the following May (i.e., the standard rate). The premium rate calculated for the aged is also paid by disability beneficiaries, who are under age 65, even though they have higher health costs than the elderly.

Since 1974 the actuarial rate per aged enrollee has increased from \$6.30 per month to \$24.60 per month. The standard rate, however, only increased from \$6.30 to \$12.20. In announcing the rate to be effective July 1, 1982, the Secretary estimated that beneficiary premium contributions from the aged will be equal to 24.8 percent of anticipated part B costs for the aged.

Committee amendment.—The committee amendment establishes and maintains the Part B premium paid by aged enrollees at 25 percent of program costs. Disabled enrollees would continue to pay the same premium amounts as the aged. The premium amount for the 12-month period beginning July 1, 1982, would be adjusted to \$12.30 on October 1, 1982, an increase of \$0.10 over the current amount.

Effective date.—Premiums paid on or after October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$36
1984.....	204
1985.....	499

LIMIT MEDICARE REIMBURSEMENT TO HOSPITALS

(Section 110 of the Bill)

Present law.—Under present law and regulations, Medicare reimburses hospitals (as well as skilled nursing facilities and home health agencies) on the basis of the “reasonable costs” they incur in providing covered services to beneficiaries, excluding any part of such costs found to be unnecessary in the efficient delivery of needed services. Reimbursement for hospital routine operating costs (i.e., bed, board and routine nursing care) may not exceed a limit (known as the Sec. 223 limit) based on similar costs incurred by comparably situated hospitals. Under this limitation, a hospital may not be reimbursed for more than 108 percent of the average routine cost per day incurred by other hospitals of the same type, unless it qualifies for an exception or an exemption.

In brief the calculation of the section 223 limit involves: identifying the inpatient general routine operating costs for each hospital, adjusted for certain factors; calculating the mean (average) of the adjusted routine operating costs of the comparable hospitals in a group; applying the reimbursement limit (currently 108 percent) to the mean to establish a limit for each hospital grouping; and making certain adjustments to the limits when applied to individual hospitals. Inpatient routine per diem costs in excess of the applicable limits are not reimbursable by the Medicare program. If a hospital’s allowable per diem costs are under the Sec. 223 limits, the facility is reimbursed for its reasonable costs.

Committee amendment.—Hospital spending has been increasing at double-digit rates for over a decade and much faster than the rates of inflation in the economy as a whole. Hospital spending accounts for over 70 percent of Medicare program expenditures and the persistently large increases in hospital costs are now threatening the financial soundness of the Hospital Insurance Trust Fund.

The committee amendment addresses the problem of Medicare program spending for hospital care by (a) expanding the existing section 223 limits on inpatient general routine per diem operating costs to hospital ancillary operating costs and special care unit operating costs as well, establishing an overall limit on hospital inpatient operating costs per case, (b) establishing a short-term, temporary limit on annual rates of increase in hospital reimbursement per case, and (c) the direction development of methods under which hospitals, skilled nursing facilities and other providers would be paid on the basis of prospectively established rates.

a. *Expansion of section 223 limits to include ancillary costs.*—The committee amendment modifies the existing section 223 limitations by: (1) exempting from the limits small (under 50 bed) rural hospitals; (2) extending the limits to include hospital ancillary operating costs (e.g., lab services, X-rays, drugs, etc.) and special care unit operating costs; (3) increasing the current limit from 108 percent to 110 percent; (4) applying the limit on an average operating cost-per-case basis; and (5) adjusting each facility’s limit to take into account the needs of its particular patients compared to the needs of patients in other hospitals with which it is being compared (by making “case-mix” adjustments). The Secretary is expected to recalculate such adjustments periodically.

The Committee understands that initially the Secretary will need to rely on a currently available indicator of case mix complexity such as the system developed at Yale University. The committee expects that the Secretary will continue to evaluate possible method for adjusting for case mix and will adopt an improved method when it becomes available.

The limits will be applied to total inpatient operating costs per case, rather than inpatient routine operating costs per diem. The committee believes that, by including ancillary and special care unit operating costs under the section 223 limits, it will be possible to look at overall costs involved in caring for Medicare patients and will permit payment to be made on a per case rather than per-day basis, thereby removing any incentives to keep patients longer than absolutely necessary. The committee also believes that such information on the costs of care will assist in the development of a prospective payment system.

The committee expects that in most other respects the current methods used to develop limits on routine operating costs will form the basis for initial application of the new 'limits,' e.g., hospitals will continue to be classified into comparison groups and factors such as area wage differences will be recognized.

Historical cost data updated to reflect average actual and anticipated cost increases, would be used to develop the cost limits. The measure used to determine anticipated cost increases will be a market basket measure of the prices paid by hospitals for supplies and services, plus 2 percentage points.

The current days of care adjustment now used in establishing the routine operating cost limits would be eliminated. A new exceptions basis would be established for changes in case mix caused by significant changes in a hospital's operation or organization (e.g., the addition of a new service). The Secretary would be required to retain exceptions from application of the limits for costs arising from: (1) the provision of atypical services required by patients, (2) extraordinary circumstances beyond the provider's control, (3) providers in areas of fluctuating population, (4) medical and paramedical education, (5) the provision of essential community hospital services, and (6) for unusual labor costs. Also the committee anticipates that the Secretary would continue to apply any other exemptions, exceptions and adjustments now allowed under the routine operating cost limits that he deems appropriate for the new overall limits on operating costs.

In no case would a hospital's reimbursable cost per case be reduced below the per case costs that were reimbursable by Medicare for the cost reporting period that immediately preceded the first reporting period subject to the new limits.

The Secretary is directed to determine the extent to which the new hospital reimbursement limits for certain public hospitals and other institutions including public benefit corporations, should be adjusted to take into account the extra costs that they necessarily incur in treating low-income patients. Such an adjustment if warranted would be made beginning with the first year the limit is in effect. It is recognized that it may not be possible to establish an appropriate adjustment in time to apply it prospectively. Therefore it may be necessary for the initial application of the adjustment to be made retroactively.

The Secretary would develop adjustments under this and the following section (b) to assure that the proposed limits would not be significantly compromised if a hospital reduces its costs by cutting back on the kinds of services it provides directly to its patients—e.g., by leasing out its clinical laboratory.

This part of the amendment would be effective for hospital accounting periods beginning on or after October 1, 1982.

b. 3-year limit on hospital reimbursement increases.—Under present law, there is no limitation on the percentage by which a hospital's reimbursable costs may increase from year to year. The committee amendment provides that Medicare would not reimburse a hospital for operating costs incurred in any of the first three of its cost-reporting periods beginning on or after October 1, 1982, to the extent that they increase in excess of a specified percentage. The committee intends this provision as a short-term measure to hold down the rate of growth of hospital insurance benefits until a workable system of prospective hospital payments can be developed to replace the retrospective cost-based reimbursement system now used.

Under the amendment, the base period will be the cost reporting period immediately preceding the first cost reporting period to which the limit applies. The allowable annual rate of increase in inpatient operating costs per case will be the rate of increase in a market-basket measure of the prices paid by hospitals for supplies and services, plus 2 percentage points. For example, if a hospital reports its costs to Medicare on a calendar-year basis its cost ceiling for allowable costs per case in 1983 will represent an increase of not more than market basket plus 2 percent (10 percent approximately) over its allowable cost per case in 1982. Similarly, its allowable rate of increase per case for 1984 and 1985 could not increase in excess of market basket plus 2 percent above the limit calculated for the previous year. For the first 2 years the amendment is in effect, hospitals would be paid 25 percent of any otherwise allowable costs that are in excess of the rate of increase limit; no payment would be made for amounts in excess of the rate of increase limit during the third year. This rate of increase limit on Medicare reimbursement would expire at the end of the hospital's third post September 30, 1982, cost reporting period, unless a prospective payment system is put into place prior to that time, in which case this limit on Medicare reimbursement would cease upon implementation of the new system.

The Secretary will provide an exceptions process to take into account factors that would distort either a hospital's base period or rate of cost increase during the 3-year limit period. Examples of such factors include significant changes in a facility's case-mix in a particular year when compared to the base year or extraordinary circumstances beyond the facility's control.

This part of the amendment would be effective for reporting periods beginning on or after October 1, 1982 (but not to exceed 36 months for any hospital).

c. Prospective payment for hospitals and skilled nursing facilities.—Under present law, hospitals and skilled nursing facilities are paid on the basis of the costs they incur in caring for Medicare patients. While the limits in present law tend to penalize some inefficient institutions,

no provision is made to allow efficient institutions to benefit. Also, the amount of a hospital's reimbursement cannot be accurately determined until sometime after the close of the cost-reporting period in which the costs were incurred. Therefore, hospitals are restricted in their ability to engage in sound financial planning.

The committee amendment directs the Department of Health and Human Services to develop, in consultation with the Senate Finance Committee and House Ways and Means Committee, legislative proposals under which hospitals, skilled nursing facilities and, if feasible, other providers would be paid on a prospective basis. Because of the committee's interest in prospective payment the results of the State Medicare reimbursement demonstration are of great interest. Full and complete evaluation of these demonstrations will provide necessary information for legislative decisions on Medicare reimbursement.

The Department would be required to report its recommendations no later than 5 months after the date of enactment.

Effective dates.—Note above description.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$610
1984.....	1, 720
1985.....	3, 120

REQUIRE CERTAIN MEDICARE REGULATIONS

(Sections 111–114 of the Bill)

The amendment requires the Secretary to issue regulations for the following regulatory initiatives included in the President's Fiscal Year 1983 Budget.

a. Elimination of private room subsidy

Present law.—Under current law, medicare covers semiprivate room accommodations in a hospital and skilled nursing facility, except where private accommodations are medically necessary or where semiprivate accommodations are unavailable. Medicare reimburses for such services on the basis of allowable reasonable cost. However, since Medicare currently bases its payments to hospitals on the basis of the average costs for all its accommodations, the reimbursement indirectly includes the additional costs of private rooms even though Medicare is only supposed to cover the cost of semiprivate rooms.

Committee amendment.—The amendment requires the Secretary to publish regulations which would eliminate the subsidy of the estimated extra cost of private rooms. Initially this may be accomplished by subtracting from a provider's allowable costs the estimated differential costs based on the differential charges for private rooms over semiprivate rooms. Medicare, however, will continue to pay the estimated private room differential cost for medically necessary private rooms used by program beneficiaries. The decrease in reimbursement as a result of this provision may not be passed along to beneficiaries.

Effective date.—Cost reporting periods beginning on or after October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$54
1984.....	75
1985.....	80

b. Establish a single reimbursement limit for skilled nursing facility and home health agency services

Present law.—Under current law, the Secretary is authorized to set prospective reimbursement for providers of services under Medicare on the basis of estimates of the costs necessary for the efficient delivery of needed health services. Reimbursement limits for skilled nursing facilities (SNFs) have been established for inpatient general routine service costs. These limits are currently set at 112 percent of the average operating costs of each comparison group. Cost limits for home health agencies (HHAs) are set at the 75th percentile of average per visit cost for each group.

Allowable costs for services provided by skilled nursing facilities and by home health agencies generally vary depending on whether the skilled nursing or home health services are delivered through hospital-based or in free-standing facilities. Separate payment limits are currently established for services rendered in each type of setting.

Committee amendment.—The amendment requires the Secretary to modify existing regulations by establishing a single payment limit that would be based on the cost experience of free-standing facilities. The committee expects that this provision will encourage more efficient behavior on the part of hospital-based facilities. The Secretary would be authorized to establish adjustments or exceptions, as appropriate, based on legitimate cost differences in hospital-based facilities resulting from such factors as more complex case-mix or effects of medicare cost allocation requirements.

Effective dates.—HHA services, cost reporting periods beginning on or after the date of enactment; SNF services, cost accounting periods beginning on or after October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$18
1984.....	46
1985.....	46

c. Eliminate duplicate overhead payments for outpatient services

Present law.—Public Law 97-35 required the Secretary, to the extent feasible, to establish, by regulation, limitations on costs or charges that are to be considered reasonable for outpatient services provided by hospitals or clinics (other than rural health clinics) and by physicians utilizing these facilities. Limitations are to be reasonably related to the actual charges (not Medicare-determined reasonable charges) in the same area for similar services provided

in physicians' offices. Limitations are not to apply with respect to bona fide emergency services provided in hospital emergency rooms. Further, the legislation requires the Secretary to provide for exceptions to the limitations in cases where similar services are not generally available to Medicare beneficiaries in physicians' offices in the area.

The location where a physician's service is performed (i.e., physicians' office or hospital outpatient department) has an important bearing on whether there are overhead costs for which he is responsible. While a physician pays for his office overhead (e.g., utilities, nursing staff, etc.), similar costs for services he renders in an outpatient department are borne by the hospital and covered by the hospital's reimbursement.

Committee amendment.—The amendment requires the Secretary to issue regulations that would eliminate the duplicate payment of overhead expenses in cases where a physician performs services in a hospital's outpatient department. This would be achieved by reducing the prevailing charge screens to eliminate the overhead component. The Secretary is now required to calculate an overhead factor in order to determine the percentage by which physicians prevailing charges may increase under the economic index provisions. Currently, it is estimated that approximately 40 percent of physicians' fees are for overhead. The committee thus expects that refined prevailing charge screens for physicians who practice in settings where they are not personally responsible for overhead expenses will be reduced by the same percentage as that used in implementing the economic index. Medicare will continue to pay 80 percent of the reasonable charges that result from the revised screens.

Effective date.—Charges for services rendered on or after October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$160
1984.....	225
1985.....	270

AUDIT AND MEDICAL CLAIMS REVIEW

(Section 115 of the Bill)

Present law.—Under current law and regulations, Medicare contracts with intermediaries and carriers to perform a variety of day-to-day administrative and operational tasks for the program, including the review of claims and the conduct of audits.

Committee amendment.—The amendment requires that the Medicare contractor budgets for fiscal years 1983, 1984 and 1985 be supplemented by \$45 million in each year to be spent specifically for contractor audit and medical review activities.

The fiscal year 1983 budget request for Medicare contracting is insufficient to assure adequate medical review and audit by intermediaries and carriers. As a result, the program stands to lose benefit dollar savings through a failure to identify improper billings and

detect reported costs that are not reimbursable. The committee believes that adequate funding of medical review and audit activities is necessary if cost-effective program management is to be achieved. The committee intends that these funds not supplant funds that would otherwise be appropriated for these purposes, but rather that they supplement these amounts.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$130
1984.....	300
1985.....	300

TEMPORARILY DELAY PERIODIC INTERIM PAYMENTS

(Section 116 of the Bill)

Present law.—Under current reimbursement arrangements, hospitals receive payments for services provided to Medicare beneficiaries under one of two different procedures. Under the standard approach, hospitals submit bills and receive payments on the basis of such billings. The average timelag between the date of service and the date of payment under this approach is about 6 weeks. An alternative approach permits hospitals to receive periodic interim payments (PIP) which are not directly tied to the receipt of bills. On average, this payment procedure results in a 3-week lag between the rendering of services and the receipt of payment.

Committee amendment.—The amendment changes the periodic interim payment procedure by providing for a delay in the flow of PIP payments during September 1983, so that the lag for payments to hospitals that use this procedure will increase to about six weeks during the delay. The deferred payments would be paid to the hospitals affected by this delay in October 1983. The bill makes a similar deferral of PIP payments during September 1984.

The committee further recognizes that even so short an interruption in cash flow could cause substantial financial distress to providers with insufficient working capital and who are unable to obtain a short-term loan. This could be particularly critical for hospitals which receive a substantial portion of their revenues from the Medicare program. In these few cases, the committee expects the Secretary of HHS to utilize existing regulations which provide for accelerated payments for providers in financial difficulties.

To minimize hardship to hospitals affected by the proposal, the committee expects the deferred reimbursement amounts to be paid promptly in the new fiscal year, and that any interest expenses which hospitals are required to incur by hospitals as a result of borrowing to meet cash flow requirements during the deferral period will be included in such hospitals allowable costs.

Effective date.—September 1983.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$750
1984.....	100
1985.....	—870

ASSISTANTS AT SURGERY

(Section 117 of the Bill)

Present law.—Under current law and regulations, part B carriers are given discretion for reimbursing assistants at surgery (i.e., physicians who assist the primary surgeon during an operation). Generally speaking, the carriers follow local medical practice and/or private sector reimbursement policies.

Committee amendment.—Historically, many carriers have allowed assistants at surgery to bill fees (typically 20 percent of the primary surgeon's fee) only in hospitals in which approved residency training programs did not exist in that specialty. The rationale for not permitting assistants at surgery to bill fees in teaching hospitals has been that fully qualified house staff are available to serve in the capacity of assistants at surgery. Hospitals are reimbursed by Medicare on a reasonable cost basis for the salaries of such house staff. However, there has been a recent trend for carriers to allow charges for assistants at surgery who are not residents even in situations where a training program exists in that specialty.

The amendment would prohibit reasonable charge reimbursement for an assistant at surgery in hospitals where an approved training program exists in the specialty, except under the following exceptional circumstances: (1) the service is complex and requires performance by a team of physicians as in the case of coronary bypass operations, (2) the patient has multiple conditions which require the presence of and active care by a physician of another specialty during an operation, and (3) emergency situations or circumstances where qualified house staff is not available to assist at surgery. The Secretary is directed to define each of these situations more specifically. The Secretary is also directed to develop appropriate methods for reimbursement of assistants at surgery where their services are covered.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$55
1984.....	130
1985.....	150

JUDICIAL DISTRICT IN WHICH PROVIDERS MAY OBTAIN
JUDICIAL REVIEW

(Section 118 of the Bill)

Present law.—Under existing law an individual provider of Medicare services may have an adverse decision of the Provider Reim-

bursement Review Board (PRRB) reviewed by the U.S. district court for the district in which the provider is located or, alternatively, in the U.S. district court for the District of Columbia. However, because of the language of the current medicare statute, actions brought jointly by several providers may be taken only in the U.S. District Court for the District of Columbia.

Committee amendment.—The amendment permits Federal judicial review of adverse decisions of the Provider Reimbursement Review Board involving actions brought jointly by several providers of medicare services to be conducted by the U.S. district court for the district where the “principal party” for the group is located. The committee expects that in defining “principal party,” the Secretary’s regulations would establish objective criteria that would prevent “forum shopping.” Additionally the committee expects that, ordinarily, the principal party to a suit would be the providers’ headquarters office, if the parties are commonly owned or, in the case of independent providers, the party with the most money at stake.

Effective date.—Enactment.

Estimated savings.—N.A.

REIMBURSEMENT FOR LESS THAN EFFECTIVE DRUGS

(Section 118 of the Bill)

Present law.—Section 2103 of the “Omnibus Budget Reconciliation Act of 1981” (P.L. 97-35) prohibited, effective October 1, 1981, the use of Federal funds under Medicare part B and under Medicaid to pay for certain drugs. These are ones that the Food and Drug Administration has proposed in a notice of opportunity for hearing, to withdraw from the market because they are less than effective; also included are identical, related, or similar drugs. Implementing regulations issued October 1, 1981 provided for a grace period until January 1, 1982 before enforcement of the provision. However, on October 23, 1981, in a lawsuit brought in the U.S. District Court for the District of Columbia, the court held that the Secretary was not authorized to grant a grace period; it ordered the Secretary to discontinue reimbursement for the subject drugs effective October 30, 1981.

Public Law 97-72, signed into law on December 15, 1981, continued appropriations for the government through March 31, 1982. This law incorporated by reference a provision in the appropriations bill passed by the House on October 6, 1981; the House provision provided that: “None of the funds appropriated or otherwise made available in this title may be used to pay the salaries of officers and employees for implementation or enforcement of section 2103 of the Omnibus Budget Reconciliation Act of 1981 or for the implementation or enforcement of rules or regulations pursuant to such section.” The provision was approved by the Senate with the understanding that it would expire on April 1, 1982. However, the provision was automatically extended until September 30, 1982, when, on March 31, 1982, the President signed Public Law 97-161 which extended the effective date of Public Law 97-72 through September 30, 1982. The Department published a notice in the Federal Register on April 16, 1982 providing for the continued reimbursement of the subject drugs through September 30, 1982.

Committee amendment.—The amendment provides, effective on enactment, for implementation of Section 2103 of the “Omnibus Budget Reconciliation Act of 1981.” The committee notes that the provision is intended to preclude Federal payments only for drugs which have been determined after careful review by the FDA to have been less than effective in use. The committee expects that the Department will devote sufficient resources to assure adequate implementation of the section.

Effective date.—October 1, 1982.

Estimated savings.—NA.

MEDICARE PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS (HMO'S)

(Section 120 of the Bill)

Present law.—Health Maintenance Organizations (HMOs) are reimbursed by the Medicare program for services covered under both Parts A and B of Medicare according to the authority established in Sec. 1876 of the Social Security Act. Section 1876 defines an HMO as a legal entity which makes Medicare covered services available in a geographic area on a prepayment basis. At least one-half of an HMO's membership must be persons under age 65, although the Secretary is permitted to waive the 50 percent requirement for up to three years. All Medicare beneficiaries entitled to part A and/or B services, are eligible to enroll in an HMO serving the geographic area in which they live.

Under section 1876, HMOs receive interim monthly capitation payments for services furnished to Medicare beneficiaries according to one of two types of contracts, cost or risk. HMOs which are paid under cost contracts are reimbursed for the reasonable costs of providing covered services to Medicare enrollees according to Medicare's cost principles of cost reimbursement.

An HMO is eligible to enter into risk sharing contract if it is a mature HMO. A mature HMO is one which (1) has at least 25,000 members and which has served as the primary source of health care for at least 8,000 persons in the two years immediately preceding the contract, or (2) serves non-urban areas with current enrollments of not less than 5,000 members and which has served as the primary source of health care for at least 1,500 persons in the 3 years immediately preceding the contract. Under risk contracts, reimbursement is based on a comparison of the HMO's costs with its Adjusted Average Per Capita Cost (AAPCC), which is the average cost of providing services to Medicare beneficiaries in the same geographic area as the HMO but not enrolled, and having the same characteristics as the enrolled population. If the risk-based HMO's costs are less than the AAPCC, it shares the “savings” with the Medicare program and it may receive savings up to 10 percent of its AAPCC. HMO's are not required to provide additional benefits with their savings. If the HMO's costs are higher than its AAPCC, the HMO must absorb the loss, which may be carried forward and offset against future savings.

Committee amendment.—The committee amendment would amend section 1876 of the Social Security Act by authorizing prospective re-

imbursement under risk-sharing contracts for what are known as "competitive medical plans" (defined below) at a rate equal to 95 percent of the AAPCC. There would be no limit on the "savings" the plan could retain.

If the Secretary determines a competitive medical plan does not have the capacity to bear the risk of potential losses under a risk-sharing contract, or if it has less than 1,000 members, the plan must enter into a reasonable cost reimbursement contract under which reimbursement would be on the basis of reasonable cost. Other competitive medical plans may also elect to contract on a cost basis. As under current law monthly per capita payments to plans under such cost contracts would be subject to retroactive corrective adjustment, and certain financial data and administrative requirements would be required.

Under the committee amendment, Medicare payments would be made to a competitive medical plan with a risk-sharing contract on a per capita basis for each class of Medicare beneficiaries enrolled in the plan the classes of individuals would be based on factors including at a minimum, age, sex and disability status. The Secretary could add to, modify, or supplant these factors if such actions would add to the accuracy of the actuarial projection. In making an adjustment for disability status the Secretary may consider such factors as an individual's mental and physical condition, then prior utilization of health services and their ability to participate in activities for daily living. It is the Committee's intent that eligibility for cash payments under the Disability Insurance program or under SSI not be used as a determinant of disability status. The rate for each class would be 95 percent of the average per capita cost in the geographic area for individuals with similar characteristics but who receive services outside the plan. For an individual covered under a risk-sharing contract, only the plan (not the enrollee or any other person or entity) could receive Medicare reimbursement for services provided to enrolled Medicare beneficiaries.

The proposed amendment defines a "competitive medical plan" as a public or private entity, organized under the laws of any State, which is a qualified HMO (as defined in section 1310(d) of the Public Health Service Act), is a State-licensed HMO, or meets certain requirements, including providing to all its enrolled members; physician services, inpatient hospital services, laboratory, X-ray, and emergency services, and out of area coverage; being compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment made on a periodic basis without regard to the date the health services are provided after the date of enrollment and the amount of which is fixed without regard to frequency, extent, or kind of health care services actually provided to a member; providing physicians' services through physicians who are employees or partners of the plan or through contracts with individual physicians or groups; assuming full financial risk, with certain exceptions, on a prospective basis for the provision of required health care services; and providing against the risk of insolvency.

Each competitive medical plan must provide to its Medicare enrollees at least the health services listed under parts A and B of Medicare which are available to individuals residing in the geographic area served

by the plan. Plans must have an open enrollment period of at least 30 days every year and must accept Medicare beneficiaries in the order in which they apply, with certain exceptions to be determined by the Secretary. A plan may not expel or refuse to reenroll an individual because of health status or requirements for health care. In addition, plans must reimburse for emergency services provided outside the plan; provide meaningful hearing and grievance procedures; have programs for review of medical care. In addition, at least one-half of its membership must be persons not entitled to Medicare or Medicaid benefits, except under certain circumstances.

Under the committee amendment, a plan's cost sharing requirements with respect to medicare covered services may not exceed the actuarial value of the coinsurance and deductibles which would be applicable to Medicare beneficiaries not enrolled in the plan.

The committee amendment also provides that if the adjusted community rate (defined as either the rate of payment for medicare covered services determined under a community rating system defined under the Public Health Service Act, or the portion of a plan's aggregate premium determined to be attributed to Medicare covered services adjusted for utilization differences between Medicare and non-Medicare enrollees) for services to enrolled Medicare beneficiaries is less than the AAPCC, the plan must use the differences to (1) provide additional benefits or services, (2) reduce premiums, deductibles or copayments, or (3) provide rebates or dividends to enrolled Medicare beneficiaries.

All individuals entitled to services under parts A and B, or part B only, of Medicare, except individuals medically determined to have end-stage renal disease, would be eligible to enroll with any plan which has a Medicare contract and serves the geographic area in which the individual resides.

In addition, under the committee amendment, three new Medicare members must enroll in a plan for every current Medicare enrollee allowed to convert to the new system. The proposal provides that the prospective payment system would not be effective until the later of the first day of the thirteenth month after enactment, or one month after the Secretary notifies the Senate Finance Committee and the House Committees on Ways and Means and Energy and Commerce that he is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented.

Effective date.—Note above description.

Estimated savings.—NA.

B. PROVISIONS RELATED TO MEDICAID

ALLOW NOMINAL MEDICAID COPAYMENTS

(Section 131 of the Bill)

Present law.—Under current law, States are not permitted to impose cost-sharing charges on mandatory services provided to the categorically needy. They are permitted but not required, to impose such charges on all services for the medically needy and on optional services

for the categorically needy. All cost-sharing charges must be nominal in amount.

Committee amendment.—The amendment provides States with greater flexibility in administering their Medicaid programs by permitting them to impose nominal copayments on all beneficiaries for all services with certain exceptions. States would be precluded from imposing such charges with respect to: (1) inpatient hospital and the mandatory ambulatory services provided to categorically needy children and services related to the pregnancy of categorically eligible women; and (2) all services provided to categorically needy inpatients in medical institutions who are required to spend, except for a personal needs allowance, all their income for medical expenses. The committee recognizes that it may not be operationally feasible for States to ascertain in all cases whether recipients for whom claims are submitted were pregnant. The committee intends that copayments not be imposed with respect to the specified services when it can be determined from the provider's claim submitted for payment that the service provided was related to routine prenatal care, labor and delivery, routine postpartum care, complications of pregnancy or delivery or other medical conditions likely to affect the pregnancy (e.g., hypertension, diabetes, urinary tract infection).

The amendment permits States, at their option, to exempt two classes of individuals from any cost-sharing charges which the State chooses to impose. These two classes are: (1) inpatients in medical institutions, whether categorically needy or medically needy, who are required to spend, except for a personal needs allowance, all their income for medical expenses, and (2) Medicaid recipients who are enrolled in health maintenance organizations. The committee notes that, for institutionalized individuals, cost-sharing for services other than those provided by the institution does not reduce the States' outlays for medical care and creates major administrative complexities. In addition, the committee believes it would be inequitable to require institutionalized individuals to pay cost-sharing charges out of their small personal needs allowance. The committee further recognizes that permitting States to exempt HMO enrollees from cost-sharing charges may simplify State negotiations with HMOs and may encourage more Medicaid recipients to enroll in HMOs.

The amendment provides that the cost-sharing imposed under this section is to be "nominal" in amount. The committee notes that existing regulations specify that the State can only impose one type of cost-sharing charge for each type of service. Currently for noninstitutional services, the following maximums are placed on allowable charges: (a) deductibles cannot exceed \$2 per month per family; (b) coinsurance may not exceed 5 percent of the State's payments for the services; and (c) the maximum copayment chargeable to the recipient can range from \$0.50 to \$3.00 depending on the State's payment for such service. Currently for institutional services, the maximum beneficiary charge cannot exceed 50 percent of the payment the State agency makes for the first day of care in the institution. While not precluding changes in the current regulations, the committee expects similar maximum limits to be applied for the allowable charges permitted under this provision.

Further, the committee expects that the Secretary, in reviewing a State's proposed cost-sharing charges to determine if they are nominal, will consider the monthly amounts paid by the State as cash assistance under the State's AFDC program, and the income standards used to determine eligibility for the medically needy, as well as the costs of the specific medical services. Finally the amendment assures that recipients are not denied emergency care or other needed services because they are not able to pay required copayment amounts as a precondition to securing such services.

Effective date.—Enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$42
1984.....	47
1985.....	53

ELIMINATE MATCHING RATE FOR MEDICINE PART B "BUY-IN"

(Section 132 of the Bill)

Present law.—Most State Medicaid plans pay the monthly Medicare Part B premium payment for their dual eligible beneficiaries under a "buy-in" agreement. While States may buy-in to Medicare for both their cash assistance and medically needy populations who are eligible for Medicare federal matching for premium payments is available only for the cash assistance group. If a State does not buy in for Part B coverage, it cannot receive Federal matching payments for services that would have been covered under Medicare if there had been a buy-in arrangement. Four States and two jurisdictions do not currently have a buy-in arrangement. These are: Alaska, Louisiana, Oregon, Wyoming, the Northern Mariana Islands, and Puerto Rico. Alaska's buy-in agreement becomes effective October 1, 1982.

Committee amendment.—The amendment eliminates Federal matching for all Medicare Part B premium payments, effective with respect to premiums due for months after September 1982. The committee notes that the current combination of the 75 percent Federal general revenue subsidy for part B (for all Medicare part B eligibles) coupled with the Federal match for Medicaid eligibles results in a Federal subsidy of close to 90 percent for part B services for this population group.

Effective date.—Premiums due for months after September 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$203
1984.....	216
1985.....	230

MODIFY LIEN PROVISIONS

(Section 133 of the Bill)

Present law.—Under current law, States are barred from imposing any lien against any recipient's property prior to his death because of

Medicaid claims paid or to be paid on his behalf unless placed as a result of a court judgment. In the case of individuals under age 65, no adjustments or recoveries can be made for Medicaid claims correctly paid. In the case of individuals over 65, adjustments and recoveries for correctly paid claims can only be made from his/her estate after the individual's death and only (1) after the death of his surviving spouse; and (2) where there are no surviving children who are under 21, blind, or disabled.

Further, under current law, States may deny medicaid eligibility to applicants who, within the previous 24 months, transferred for less than fair market value resources which, if retained, would have made them ineligible for the program. However, in most instances the applicant's ownership of a home would not make him or her ineligible for medicaid.

It is therefore possible, under current law, for an elderly individual who anticipates needing nursing home care to give his/her home to a family member or friend without fear of losing or being denied medicaid eligibility. By so doing, the individual assures that the home will not be part of his/her estate and therefore will not be subject to any recovery action initiated by the State after the individual's death.

Committee amendment.—The amendment intends to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance government's legitimate desire to recover its medicaid costs against the individual's need to have the home available in the event discharge from the institution becomes feasible.

The amendment has two parts. First, it allows States to deny Medicaid eligibility temporarily to patients in medical institutions who dispose of a home for less than fair market value, even though such disposal would not make them ineligible for supplemental security income (SSI). States could either deny eligibility to all such individuals for periods reasonably related to the uncompensated value, or they could deny eligibility in all cases for a minimum of 24 months, with the option to provide for longer periods of ineligibility in the case of individuals who disposed of homes worth substantial amounts. The provision would not apply in the case of individuals who reasonably expected to be discharged from the medical institution and return home; individuals who demonstrated that they had intended to obtain fair market value or other valuable consideration in exchange for their homes; or individuals who transferred title to their homes to a spouse or a minor or handicapped child. The State could also make an exception in other cases where undue hardship would otherwise result.

Second, the amendment would allow States to attach the real property, including the home, of medicaid recipients who are permanently institutionalized in nursing homes or other long term care medical institutions. The lien could not be foreclosed upon, and States could recover the cost of medical assistance provided to the recipient only when the recipient voluntarily chose to sell the property or, after the recipient's death, from his estate. As under current law, no recovery would be permitted while the recipient's spouse was still living or

while his/her children were still dependent (under 21, or blind, or disabled). Further, if the recipient is discharged from the institution and returns home, the lien would dissolve, and the property would be available for the recipient's use until his/her death.

The committee notes that, under current law, States are often unable to recover resources which recipients hold as homes or as income-producing real property. The amendment would facilitate States' efforts to recover medical assistance costs from these types of resources and to assure that all resources available to an individual will be used to defray the public costs of supporting that individual in a long-term medical institution.

At the same time, the committee notes that the legitimate rights of the recipient, the recipient's spouse and his/her dependent children are protected under the amendment.

Effective date.—Enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$183
1984.....	200
1985.....	221

REDUCTION IN ERROR RATE TOLERANCE

(Section 134 of the Bill)

Present law.—Under an amendment to the 1980 Appropriations Act, States were required to reduce their payment error rates for eligibility determinations to 4 percent by September 30, 1982. States whose error rates exceed the target figure are subject to a penalty reduction. The nationwide Medicaid payment error rate for the October 1980–March 1981 period was estimated at 4.1 percent.

Committee amendment.—The amendment deletes the error rate provisions and penalties incorporated in the 1980 Appropriations Act. It substitutes language establishing a 3 percent target error rate for quarters beginning after March 30, 1982. Prospective fiscal sanctions are to be applied beginning in the second half of fiscal year 1983 for States which have error rates exceeding the 3-percent figure. The annual penalty, applied on a prospective basis, will be equal to the product of (a) the portion of the projected error rate which exceeds 3 percent for the year in question and (b) the total amount of Federal financial participation expected to be claimed for the year for services provided to recipients for whom the State determined eligibility. If the estimated prospective penalty proves to be inaccurate when actual data from the period become available, appropriate adjustments will be made in subsequent grants. The Secretary is provided discretion in applying the fiscal penalties, in whole or part, for a State which has made a good faith effort to meet the 3-percent target.

The committee is aware that many questions remain to be resolved relative to the matter of sanctions for excessive rates of error. For example, under the existing provision no sanctions have in fact been imposed. However, the Administration's projections of program costs under present law appear to be based on an assumption that no waivers would be granted. The committee believes that the question can-

not be predetermined either way but must be based on a case-by-case examination by the Secretary of the situation in a State, taking into account relevant circumstances including the question of whether the State has shown a sustained record of improvement over a period of years. The committee intends that the provision be administered in a way which will achieve its objectives on a reasonable basis. The purpose of the provision is to provide a strong incentive for improved program accuracy and to avoid Federal participation in erroneous payments which could have been avoided. The committee recognizes that there are limitations on what it is possible to accomplish even with good faith efforts aimed at full compliance.

The committee has delayed the effective date for imposition of fiscal sanctions until April 1983 in order to allow it time to study the existing quality control system.

Effective date.—Enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$30
1984.....	65
1985.....	72

CONTINUATION OF MEDICAID ELIGIBILITY (Section 135 of the Bill)

Present law.—Under current law the loss of Aid to Families with Dependent Children (AFDC) eligibility often means a loss of Medicaid eligibility as well. The 1981 Reconciliation Act makes certain working families ineligible for AFDC as a result of changes in the earned income disregard and work expense deductions.

Committee amendment.—The committee amendment allows the States to continue Medicaid coverage for working families who are made ineligible for AFDC as a result of certain changes made by the 1981 Reconciliation Act.

Effective date.—Beginning with the first calendar quarter after enactment.

Estimated costs.—

Fiscal years:	Millions
1983.....	—\$1
1984.....	—1
1985.....	—1

C. PROVISIONS RELATED TO UTILIZATION AND QUALITY CONTROL PEER REVIEW

CONTRACT FOR UTILIZATION AND QUALITY CONTROL PEER REVIEW

(Sections 141–150 of the Bill)

Present law.—Under current law, Professional Standards Review Organizations (PSROs) are charged with the ongoing review of services provided under Medicare and may be contracted with by States for review under Medicaid. PSROs, where established, determine, for

purposes of reimbursement under these programs, whether services are: (1) medically necessary; (2) provided in accordance with professional standards; and (3) in the case of institutional services, rendered in the appropriate setting. The "Omnibus Budget Reconciliation Act of 1981," P.L. 97-35, required the Secretary to develop PSRO performance criteria and assess, not later than September 30, 1981, the relative performance of each PSRO. Based on this assessment, the Secretary was authorized to terminate up to 30 percent of existing PSROs. The total number of operational PSROs was reduced from 187 in May 1981 to 148 in April 1982.

Public Law 97-35 also provided for the optional use of PSROs under State Medicaid plans. States may contract with PSROs for the performance of required review activities; 75 percent Federal matching is available for this purpose.

Committee amendment.—The committee amendment repeals the existing PSRO provision and provides for the establishment of a utilization and quality control peer review program.

The committee notes that the PSRO program was established in 1972 as a result of rapidly increasing costs of Medicare and Medicaid and the failure of the existing utilization and claims review mechanisms to deal with widespread inappropriate usage of costly health care services. These problems remain today.

The committee notes that the PSRO program has had mixed results. On the positive side, peer review has afforded practicing physicians an opportunity on a voluntary and publicly accountable basis to undertake review of the medical necessity and quality of care provided. The program has demonstrated that the concept of peer review is a valid one. Where physicians are willing to work cooperatively, the program can do much to prevent unnecessary services and thereby minimize risks to patients and the waste of valuable resources that are needed elsewhere. Further the committee notes that the PSRO program has shown that these objectives can be achieved through an effective partnership between the Government and the private sector.

The PSRO program has, however, been faced with certain structural problems. Overregulation and too detailed specifications in laws have restricted innovation in new approaches to review. The private sector must be encouraged to institute approaches designed to assure quality while eliminating unnecessary services. Administrative functions of organizations engaged in review activities can and must be arranged in a more cost-effective manner.

The bill capitalizes on the positive aspects of the PSRO program and enables entities who have proven their effectiveness to enter into performance based contracts for the conduct of peer review.

The bill requires the Secretary to enter into contracts with peer review organizations for an initial period of 2 years, renewable biennially, for the purpose of promoting the effective, efficient, and economical delivery of quality health care services under Medicare. The organizations must be composed of, or have available to them a substantial number of licensed doctors of medicine or osteopathy actually practicing in the area. Priority consideration must be given to organizations that are representative of the physicians in the area—that is, to physician-sponsored organizations which have the general support of the physicians in the area. Payor organizations (i.e., insurance com-

panies and similar entities) and provider organizations will be excluded from consideration during the first 12 months that contract applications are considered. Organizations who do not write health insurance policies, collect premiums or assume an underwriting function, would not be considered an insuring organization for purposes of this section.

The bill requires the Secretary to consolidate geographic areas previously established for PSROs. It is expected that each State would generally be designated as a geographic area. Local or regional areas could be designated only if the volume of review warrants it.

The review organizations, which can be for profit or nonprofit, may review the professional activities of physicians, other practitioners and institutional and noninstitutional providers in providing services to Medicare beneficiaries subject to the provisions of these contracts. The review will focus on (1) the necessity and reasonableness of care, (2) quality of care, and (3) the appropriateness of the setting.

The amendment provides that the determinations of the peer review organizations would ordinarily be binding for purposes of determining whether benefits should be paid. A beneficiary, practitioner, or provider who is dissatisfied with a determination made by the review organization is entitled to a reconsideration and under certain conditions to further administrative reviews and judicial review.

If an organization determines that a practitioner or provider has persisted in violating his obligation to provide services which are medically necessary, meet professionally recognized standards of care and are cost-effective, it may recommend exclusion from the program. Where the Secretary fails to act on the sanction recommendation of a review organization within 120 days, the practitioner or provider in question will be excluded from Medicare reimbursement until the Secretary determines otherwise.

The amendment modifies the waiver of liability provision of present law under which hospitals and other providers of services may receive payments for medically unnecessary care under certain circumstances. Under the bill, the review organization would have authority to limit applicability of a waiver of liability granted by an intermediary or carrier so that payment would be denied for services that are part of a pattern of inappropriate utilization. Payment would be withheld in these cases only where the provider has had an opportunity to correct the abuse but has failed to do so.

The amendment clarifies the confidential nature of data acquired by a peer review organization. An organization, in carrying out its functions under contract will not be considered a Federal agency for purposes of the Freedom of Information Act.

The committee has been impressed by the number of non-government entities wishing to contract with PSROs for the performance of review activities. The amendment facilitates the performance of private review by requiring a peer review organization to make available its facilities and resources to private payors paying for health care in its area on a contract basis. Medicare providers would continue to be required to release medical records of Medicare patients and to release the same type of information on private patients if so authorized.

As under present law, States could choose to use these organizations or any others to review care received by medicaid patients. The Fed-

eral Government will provide a 75 percent match for the cost of the review of Medicaid patients.

The new flexibility that the bill would give to review organizations and the Federal Government in negotiating contracts will place many new demands on medicare contract administrators. It is the committee's intent that the Department devote the full resources to this effort that will be needed.

Effective date.—Enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$15
1984.....	15
1985.....	20

D. PROVISIONS RELATED TO AID TO FAMILIES WITH DEPENDENT CHILDREN

(Subtitle D of Title I)

ROUNDING OF ELIGIBILITY AND BENEFIT AMOUNTS

(Section 151 of the Bill)

Present law.—There is no provision in current law relating to the rounding of benefits.

Committee amendment.—The committee amendment would require States to round both their need standard and actual monthly benefit amounts to the lower whole dollar. (A similar change is also being made in the SSI program.) This change would simplify administration of the program and would have a minimal impact on beneficiaries.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$9
1984.....	10
1985.....	10

EFFECTIVE DATE OF APPLICATION ; PRORATION OF FIRST MONTH'S AFDC BENEFIT

(Section 152 of the Bill)

Present law.—Current regulations allow States to pay benefits beginning with the first day of the month in which an application is filed. At the present time 12 States have chosen to do this. States which do not begin payments with the first of the month must begin assistance no later than the date on which the welfare agency approves the application, or 30 days from the date the application is complete, whichever is earlier.

Committee amendment.—The committee amendment would require States to pay benefits beginning no earlier than the date an application

is filed. Any payment for the month application would be prorated based on the date of application. (A similar change is being made in the SSI program.) An amendment to the Food Stamp Act requiring that the first month's food stamp benefit be prorated from the date of application was enacted in the 1981 Reconciliation Act.

Since AFDC benefits are paid only to needy families, the committee believes that benefits should not be provided for periods prior to the time when the family itself recognizes the need and requests assistance.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$13
1984.....	14
1985.....	14

ELIMINATE UNIFORMED SERVICE AS BASIS FOR AFDC ELIGIBILITY

(Section 153 of the Bill)

Present law.—AFDC is payable to needy families if the need arises because of active duty in uniformed service. The Administration estimates that about 10,000 families who are now receiving AFDC report that their need is caused by absence due to uniformed service. Any income which these families may actually receive from the absent parent is counted in determining the family's benefit.

Committee amendment.—The committee amendment would exclude absence based solely on active duty in a uniformed service as a basis for need. However, if the parent has left the home for other reasons, the family may still be eligible for assistance. In this case, as provided in present law, the custodial parent would have to assign to the State any rights to child support which have accrued.

The committee believes that the absence of a parent solely because of active uniformed duty should not be a basis of AFDC eligibility. The parent in the service should retain the responsibility for supporting any children. A companion provision (sec. 172) would require allotments from the pay and allowances of any member of the uniformed services (on active duty) when he fails to make child support payments.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$15
1984.....	17
1985.....	17

REFUSAL TO WORK

(Section 154 of the Bill)

Present law.—Current regulations provide sanctions for AFDC recipients who are required to register for the Work Incentive Pro-

gram (WIN) if they voluntarily quit work, reduce earnings, refuse employment, or refuse assignment to a community work experience project. Sanctions may not be applied in the case of persons who are not currently required to register, including persons who are employed 30 hours or more a week, or who live in an area so remote from a WIN program that their participation is precluded.

Committee amendment.—The committee amendment would give the Secretary authority to prescribe in regulations the period for which a sanction could be imposed if an individual (who is exempt from WIN registration because he is employed 30 hours or more a week, or lives in an area so remote from a WIN project that his participation is precluded): (1) refuses a bona fide offer of employment, (2) terminates employment, or (3) reduces his hours of employment, without good cause. In AFDC-UP families, assistance would be denied to the entire family. In other families, the individual who is sanctioned would be excluded from the family grant and, if the individual is the caretaker relative, protective payments would be made on behalf of the children.

The committee believes that persons who are exempt from WIN registration because of remoteness from a WIN program or because they are already employed on a substantially full-time basis should be subject to sanction when they terminate, reduce, or refuse employment. The basis for their exemption from WIN has no relation to their employability. This amendment would close a loophole in current law by applying sanctions to all employable individuals as originally intended in the law.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$1
1984.....	1
1985.....	1

MANDATORY JOB SEARCH

(Section 155 of the Bill)

Present law.—Amendments enacted in 1980 included a provision specifically authorizing Federal matching for job search activities which are part of a State's work incentive program. Both the statute and the regulations provide sanctions if a recipient who is required to register for WIN and who has been certified as ready for employment refuses without good cause to participate in job search. In the case of the principal earner in an unemployed parent family, the sanction is denial of benefits for the entire family. In other cases, the individual who refuses is removed from the grant and the family's benefit is reduced. The sanction period is 3 months in the case of a first refusal and 6 months in the case of any subsequent refusals.

Committee amendment.—The committee amendment would require each State to include in its State plan the requirement that as a condition of eligibility, individuals required to register for employment and training (or who would be required to register except for remoteness from a WIN site) will be required to participate in a program of

employment search beginning at the time of application. The individual would also be required annually to participate in a program of employment search after his application becomes effective whenever the State agency prescribes, but not more than a total of eight weeks in each year. An individual who refuses to comply with the requirement for employment search would be subject to the same penalties as an individual who refuses to comply with other work requirements.

The State would have to provide assurances to the Secretary that the employment search requirements were being complied with. There would have to be coordination between the employment search program and other programs to assure that priority is given to job placement over participation in another activity. Costs of operating the job search program would be matched by the Federal Government as an administrative cost at the 50 percent matching rate.

The committee believes that when employable individuals apply for AFDC, an attempt should be made to place them in employment while their application for assistance is being processed. There has now been considerable experience in conducting job search programs, both in the Work Incentive (WIN) program and under various demonstration programs. The evidence accumulated as a result of this experience has convinced the committee that significant numbers of AFDC applicants and recipients can be assisted in finding jobs through job search programs. For example, results from a WIN demonstration using the job club method of finding jobs for AFDC recipients showed that this method was effective for all types of recipients, even in areas of high unemployment. This demonstration, conducted in Harlem, New Brunswick, Tacoma, Wichita and Milwaukee, resulted in the placement of 62 percent of the job club participants.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$20
1984.....	50
1985.....	50

INCLUSION AND EXCLUSION OF SPECIFIED INDIVIDUALS' NEEDS AND INCOME

(Section 156 of the Bill)

Present law.—The AFDC statute does not provide a definition of what constitutes an AFDC family. The law and regulations establish certain limitations on who may be included in the family unit, and whose income and resources may be considered in determining eligibility.

Committee amendment.—The committee amendment would define in the statute those individuals whose needs must and must not be included in determining a family's AFDC benefit, and would establish rules for counting as available to the AFDC unit the income of certain individuals who are not in the family unit. Following are the basic changes from present law and regulations which would be made by the new statutory language:

Eligibility of a parent.—Current law permits States to include the needs of a parent or caretaker relative in determining the AFDC benefit so long as there is an eligible child. The child is permitted to retain eligibility to age 18 (or 19 if the child is in school and is expected to complete his course of study before reaching his 19th birthday).

The committee amendment would require States to include the needs of a parent, but only until the youngest child reaches age 16. The income and resources of the ineligible parent would be counted in determining the benefit for the child. The State would continue to include the need of a parent of an older eligible child if the parent is unemployable.

The committee believes that by the time the youngest child reaches age 16 the parent is sufficiently free from child care responsibilities to be able to undertake employment. The committee notes that about 66 percent of all mothers with children of school age are in the labor force, and that the participation of mothers of all children, and in particular of school age children, has increased rapidly in recent years. This change in AFDC eligibility rules reflects the growing participation of mothers in employment throughout the society.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$47
1984.....	48
1985.....	48

Eligibility of a child.—Current law permits families to exclude a child from the assistance unit if that child has income which would reduce the amount of the family's benefit.

The committee amendment would require States to include all children in the family unit (except disabled children receiving SSI benefits, and certain stepbrothers and stepsisters). This change will end the present practice whereby families exclude members with income, such as social security or child support payments, in order to maximize family benefits, and will ensure that the income of family members who live together and share expenses is recognized and counted as available to the family as a whole.

In addition, under current law the income of parents of a minor child who is herself the parent of a child is not counted in determining the eligibility and benefit of the grandchild.

The committee amendment would require States to count the income of the grandparents who are living in the same household as available to the grandchild, after setting aside certain amounts to cover their own needs. The AFDC payment would be made to the grandparent. The committee believes that the income of the parents of a minor child who becomes a parent should be available to the grandchild. By making the check payable to the parents of a teenage parent, the bill would give those parents opportunity to oversee the welfare of their child and grandchild.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$63
1984.....	64
1985.....	64

Counting of income of unrelated individuals.—Currently, the income of an unrelated person in an AFDC household may not be presumed to be available to the household, and the welfare agency may count only actual contributions which it knows have been made by the individual to the AFDC family.

The committee amendment would require States to count the income of any person living with the child and with the child's natural or adoptive parent if that person is not related to the child or parent or to any other individual living in the household. The income of this unrelated individual would be considered available to the AFDC family, after setting aside certain amounts to cover the needs of the unrelated person and any dependents.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$69
1984.....	70
1985.....	70

Effective date.—All three of the above provisions would be effective on enactment.

REPEAL OF EMERGENCY ASSISTANCE PROGRAM

(Section 157 of the Bill)

Present law.—The emergency assistance program provides 50 percent matching for emergency assistance (in the form of cash, medical care, or services) to families with children under a State's AFDC plan (including both AFDC and non-AFDC families). Assistance may be provided for no more than 30 days in any 12 month period. The program was enacted in 1967, and is optional with the States. In December 1980, 27 jurisdictions had established emergency assistance programs:

Arkansas	Michigan	Oregon
Connecticut	Minnesota	Pennsylvania
Delaware	Missouri	Puerto Rico
District of Columbia	Montana	Virgin Islands
Illinois	Nebraska	Virginia
Kansas	New Jersey	Washington
Kentucky	New York	West Virginia
Maryland	Ohio	Wisconsin
Massachusetts	Oklahoma	Wyoming

Committee amendment.—The committee amendment would repeal the emergency assistance program. Legislation has been proposed to make emergency assistance an allowable use of funds under the Low-Income Home Energy Assistance Block Grant.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$60
1984.....	60
1985.....	60

PRORATION OF STANDARD AMOUNT FOR SHELTER AND UTILITIES

(Section 158 of the Bill)

Present law.—AFDC regulations generally prohibit the States from prorating or otherwise reducing the AFDC benefit solely because of the presence in the household of an individual who is not legally responsible to support the family. This general prohibition was modified in Public Law 96-272 to allow States to prorate the shelter and utilities portion of the AFDC benefit in the case of “child only” family units, i.e., when the parent is not eligible for assistance.

Committee amendment.—The committee amendment would allow States to prorate the portion of the AFDC grant for shelter and utilities whenever the assistance unit shares the household with other individuals. The committee amendment gives the States flexibility in determining how the proration provision would be applied. It requires that proration be accomplished “on a reasonable basis,” and in a manner and under circumstances prescribed by the State. States would not be allowed to prorate for a recipient of Supplemental Security Income benefits to whom the one-third reduction applies. (The one-third reduction in the SSI benefit occurs when individuals are determined to be living in the household of another and receiving in-kind income in the form of food and shelter.)

The Administration had proposed that the proration provision be made mandatory on the States. The Administration proposal also prescribed how the proration was to be applied in individual cases. The committee modified this proposal, agreeing instead that whether a State prorates benefits and the method of proration should be matters decided by each State. The States themselves are better able to make these decisions, taking into consideration their own AFDC programs and caseloads. Each State would have the flexibility to decide the method of proration based on its own policy and administrative considerations. For example, a State may wish to apply proration under narrow circumstances and not prorate where the non-AFDC household members receive SSI, have little or no income (for instance, lower than the State standard of need), or are unrelated. On the other hand, a State may prorate in all situations where the AFDC assistance unit shares shelter and utilities with other individuals. The committee believes that the adoption of this optional provision recognizes the fact that where individuals share a household, the shelter and utility expenses for each individual are less.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$43
1984.....	44
1985.....	45

REDUCTION OF FEDERAL MATCH FOR PAYMENT ERRORS

(Section 159 of the Bill)

Present law.—In the four major welfare programs, AFDC, SSI, medicaid, and the food stamp program, the Federal Government and the States have established on-going “quality control” systems. These systems attempt to: (1) measure the extent and dollar value of “errors” in administration; (2) identify the types and causes of error; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

In the AFDC, medicaid, and food stamp programs, States may be “sanctioned” by being required to pay the Federal Government the Federal cost of improperly issued benefits, as shown by quality control surveys, if they do not keep their error rates below a national average or show a reduction in their error rates that meets a regularly adjusted “target improvement rate”. However, waivers of these sanctions are allowed and have, thus far, been regularly granted. The fiscal sanction that may be imposed is the amount of Federal funds misspent above what the State’s error rate would have been if it had met its target improvement rate. In the SSI system, the Federal Government is to reimburse States for their share of federally administered SSI funds misspent above a 4 percent “tolerance level”.

The regulations prescribing the AFDC sanction rules were issued pursuant to a provision in the fiscal year 1980 appropriation bill (sec. 201 of H.R. 4389), the so-called “Michel amendment”, which directed the Secretary to issue regulations requiring States to reduce their AFDC payment error rate to 4 percent by September 30, 1982. Although the bill was not enacted, the Congress adopted a continuing resolution (Public Law 96-123) to appropriate 1980 funds “to the extent” and “in the manner” of H.R. 4389, as adopted by the House on August 2, 1979. This legislation was interpreted by the Department as requiring the implementation of section 201.

Under these regulations, States are required to achieve one-third progress toward the 4-percent payment error rate (measured from their error rate for the base period April–September 1978) by September 30, 1980, and two-thirds progress by September 30, 1981. The 4-percent goal is the standard for all assessment periods after September 30, 1982.

The national average payment error rate for recent measurement periods has been: April–September 1979, 9.5 percent; October 1979–March 1980, 8.3 percent; and April–September 1980, 7.3 percent. For that most recent period, only four States had achieved the 4-percent goal: Minnesota, Iowa, Nevada, and Oregon.

Committee amendment.—For the AFDC program, the committee amendment will continue the 4-percent error rate tolerance level for fiscal year 1983 and reduce that tolerance level to 3 percent effective for fiscal year 1984 and thereafter. Until April 1, 1983, any sanctions would continue to be applied under the existing authority of the Michel amendment. Starting on that date a new sanction authority would be established. Under this new authority, Federal payments to the States will be reduced each quarter on a current basis to reflect the Secretary’s estimates as to the error rate prevailing in the State program during that quarter. If the Secretary’s estimates prove to

be incorrect when actual data become available, appropriate adjustments will be made in subsequent grants. The committee amendment continues the present authority of the Secretary to waive the sanctions in limited cases where he finds that States have failed to meet the target error rates despite a good faith effort to do so.

The committee is aware that many questions remain to be resolved relative to the matter of sanctions for excessive rates of error. For example, under the regulations in effect prior to the Michel amendment, no sanctions have in fact been imposed. However, the Administration projections of program costs under present law appear to be based on an assumption that no waivers would be granted. The committee believes that the question cannot be predetermined either way but must be based on a case-by-case examination by the Secretary of the situation in a State, taking into account relevant circumstances including the question of whether the State has shown a sustained record of improvement over a period of years. The committee intends that the provision be administered in a way which will achieve its objectives on a reasonable basis. This requires recognition that the purpose of the provision is to provide a strong incentive for improved program accuracy and to avoid Federal participation in erroneous payments. It also requires recognition of the limitations on what it is possible to accomplish even with good faith efforts aimed at full compliance.

Because of these questions the committee has deferred the effective date of the new procedure until April 1, 1983. This should allow time for the Administration to make any necessary revisions to its regulations and to consider State concerns relating to the accuracy and timeliness of the present quality review system. The committee itself intends to review the issues raised with respect to this provision during that period, and may recommend further legislation, if such action is determined to be necessary to assure that the provision operates in such a way as to achieve its purposes in an equitable and accurate manner.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$85
1984.....	129
1985.....	41

HOUSEHOLDS HEADED BY MINOR PARENTS

(Section 160 of the Bill)

Present law.—Minor parents who have children may establish their own AFDC households, so long as they meet eligibility criteria. No effort is made to keep a teenage mother in the home of her own parent or guardian.

Committee amendment.—The committee amendment would require that, in order to qualify for AFDC benefits, a minor parent and her child would have to reside in the home of the minor parent's own parent or guardian. This requirement would not apply where: the minor

parent was married at the time of (or at any time prior to) application for benefits, the minor parent has no parent or legal guardian who is living and whose whereabouts are known, the State agency determines that the health and safety of the minor parent or child would be seriously jeopardized if they lived in the same residence with the parent or legal guardian, or the minor parent lived apart from her parent or legal guardian for a period of at least one year prior to the birth of the child.

This amendment is an extension of Section 156 of the committee bill, which requires the counting of the income of parents of minors with children and requires payment of the benefit check to the parent of the minor parent if the minor parent is living with the parent.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$25
1984.....	27
1985.....	29

EXCLUSION FROM INCOME OF CERTAIN STATE PAYMENTS

(Section 161 of the Bill)

Present law.—A provision in the 1981 Reconciliation Act required States to determine AFDC benefits on the basis of the family's income in the preceding month. Under certain circumstances, payment may be determined on the basis of income in the second preceding month. This may be necessary, for example, when the payment date is in the first week of the month and the State needs time to process the monthly report of income which must be submitted by the recipient.

A State which has such a lag between the month for which income is counted and the payment date may wish to supplement the AFDC payment with a wholly State-financed payment. It may choose to do this, for example, for families which lose employment and suffer an immediate loss in income. Under present law, however, if the State decides to assist a family during a payment adjustment lag, any supplement which it pays to the family is counted as income for purposes of determining the AFDC benefit. This has the effect of reducing the next AFDC benefit check, and the State may find that it must supplement the AFDC benefit again in order to meet the family's needs. The fact that the State supplementary payment must be counted as income for AFDC establishes a cycle which may force the State to supplement the AFDC benefit on a continuing basis.

Committee amendment.—The committee amendment would allow States to exclude from calculations of AFDC benefit amounts any payments made solely from State funds that are designed to compensate for lost income in the period before the new benefit amount can be calculated and paid.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$0
1984.....	0
1985.....	0

EXTENSION OF TIME FOR STATES TO ESTABLISH A WORK INCENTIVE
DEMONSTRATION PROGRAM

(Section 162 of the Bill)

Present law.—The 1981 Reconciliation Act included a provision authorizing States to operate 3-year demonstration programs as alternatives to the current WIN program. The demonstration is aimed at testing single-agency administration and must be operated under the direction of the State welfare agency. The legislation includes broad waiver authority designed to encourage States to develop innovative programs which best meet their own State needs.

The legislation required States to submit an application to the Secretary of Health and Human Services specifying intent to operate a WIN demonstration program. This application had to be submitted within 60 days after enactment. A total of 26 States met this application deadline, indicating their intent to begin a WIN demonstration. Since that time, however, a number of these States have not followed through on their applications because of the severe cut in WIN funding for fiscal year 1982, and the proposal by the Administration to repeal the program beginning in 1983. The committee has not agreed with the Administration that WIN should be repealed, and notes that the Congress in its action on recent urgent supplemental bills has registered its desire to increase the funding which is available for 1982.

Committee amendment.—The committee amendment would allow States a period of two additional years in which to exercise their option to operate a WIN demonstration program. This would give the States until June 30, 1984 to make this decision. The committee believes that the new activities which States are planning and have recently undertaken (with respect to employment and training programs for WIN registrants) justify this amendment to further encourage the development of new programs. This extension of the period for application will give States ample time to consider their needs and the methods which they believe will be most useful in serving their AFDC applicants and recipients.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$0
1984.....	0
1985.....	0

E. PROVISIONS RELATED TO CHILD SUPPORT ENFORCEMENT

(Subtitle E of Title I)

FEE FOR SERVICES TO NON-AFDC FAMILIES

(Section 171 of the Bill)

Present law.—States are required to provide child support collection services to non-AFDC families requesting assistance. Prior to the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), States had the option of charging non-AFDC families a reasonable fee and then retaining a portion of any child support collection to pay for administrative expenses not covered by the fee. Under the Reconciliation Act provisions, States retain the option of charging non-AFDC recipients a reasonable application fee, but are required to charge a fee equal to 10 percent of the support collected. The 10 percent fee must be charged against the absent parent and added to the amount to be collected.

States have reported that because of legislative barriers and administrative difficulties, they have generally been unable to implement the requirement that the collection be charged only against the absent parent. The result is that they are unable to recover costs by using the 10 percent fee provision.

Committee amendment.—The committee amendment would repeal the provisions enacted in P.L. 97-35 which would require States, in cases involving non-AFDC families, to charge any absent parent who is obligated to pay child support through the State Child Support Enforcement Agency a fee equal to 10 percent of the child support payment. The amendment would restore the law in effect prior to P.L. 97-35 which allows States to charge a reasonable fee for a non-AFDC collection and retain from the amount collected an amount equal to administrative costs not covered by the fee. The amendment would also retain, as a State option, the authority to collect from the parent who owes child or spousal support an amount to cover administrative costs, in addition to the child support payment.

The amendment would provide that if a State elects to deduct such costs from the amount of any recovery made, the State shall have in effect a procedure under which the court or other entity which determines the amount of the support obligation will be notified of the amount by which any support collection will be reduced to reimburse the costs of collection. This would allow the court, if it finds such action appropriate, to increase the support order so that the income provided to the family will not be reduced.

Effective date.—August 13, 1981.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$12
1984.....	16
1985.....	11

**ALLOTMENTS FROM PAY FOR CHILD AND SPOUSAL SUPPORT OWED BY
MEMBERS OF THE UNIFORMED SERVICES ON ACTIVE DUTY**

(Section 172 of the Bill)

Present law.—Present law does not provide for allotments from the pay and allowances of members of the U.S. Armed Forces.

Committee amendment.—The committee amendment would add a new section to title IV-D of the Social Security Act to require allotments from the pay and allowances of any member of the uniformed service (on active duty) when he fails to make child (or child and spousal) support payments. The requirement would arise when the member failed to make support payments in an amount at least equivalent to the value of two months' worth of support. Provisions of the Consumer Credit Protection Act would apply so that the percentage of the member's pay which could be garnished would be limited. The amount of the allotment will be that of the support payment, as established under a legally enforceable administrative or judicial order.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$7
1984.....	9
1985.....	10

**REIMBURSEMENT OF STATE AGENCY IN INITIAL MONTH OF INELIGIBILITY
FOR AFDC**

(Section 173 of the Bill)

Present law.—Amounts of support collected which are sufficient to make the family ineligible for AFDC must be paid to the family beginning with the first month of ineligibility.

Committee amendment.—The committee amendment would provide that amounts collected which are sufficient to make the family ineligible would be paid to the family in months after the first month of ineligibility. This would allow the State to reimburse itself for AFDC that would have already been paid for that month before the support was collected and known to make the family ineligible. Thus, the family would not receive double payment for the same month, both in the form of AFDC and through receipt of the support collection.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$3
1984.....	4
1985.....	4

F. PROVISIONS RELATED TO SUPPLEMENTAL SECURITY INCOME (SSI)

(SUBTITLE F OF TITLE I)

PRORATE FIRST MONTH'S BENEFIT BASED UPON DATE OF APPLICATION

(Section 181 of the Bill)

Present law.—The payment of SSI benefits begins with the first day of the month in which the recipient applies and meets the eligibility requirements.

Committee amendment.—The committee amendment would prorate the first month's SSI benefit from the date of application or the date of eligibility, whichever is later. A similar change is also being made in AFDC. (A provision requiring prorating the first month's food stamp benefits from the date of application was enacted in the 1981 Reconciliation Act.) This amendment would also apply to months in which the individual reapplies after a period of ineligibility.

Since SSI is available only to the needy, the committee believes that benefits should not be provided for periods prior to the time the individual recognizes his need and requests assistance.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$26
1984.....	28
1985.....	32

ROUND SSI ELIGIBILITY AND BENEFIT AMOUNTS

(Section 182 of the Bill)

Present law.—SSI monthly benefit amounts and income eligibility amounts (which are adjusted annually to reflect changes in the cost-of-living) are rounded to the next higher ten cents.

Committee amendment.—The committee amendment would round SSI monthly benefit and income eligibility amounts to the next lower dollar. Rounding would take place after the cost of living adjustment had been made. Cost-of-living adjustments in subsequent years would be based on the *unrounded* benefit and income eligibility amounts so that the provision would have no cumulative effect from year to year. This amendment would reduce Federal outlays while having only a minimal impact on future benefits.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$20
1984.....	25
1985.....	30

COORDINATION OF SSI AND OASDI COST-OF-LIVING ADJUSTMENTS

(Section 183 of the Bill)

Present law.—A provision of the Omnibus Budget Reconciliation Act of 1981 requires that SSI benefits be determined on the basis of a monthly retrospective accounting system which replaces the quarterly prospective system existing in the past. Rather than basing SSI benefits on the applicant's or recipient's income and resources in the current calendar quarter, benefits are based on income and resources in a prior month.

Because of a defect in drafting this legislation, the annual cost-of-living increases in SSI and OASDI benefits were not coordinated. As a result, for people who receive SSI and OASDI, the new, higher OASDI benefit paid each July will not immediately be reflected in the SSI benefit. One or two months later, the SSI benefit will fall when the new, higher income is taken into account.

Committee amendment.—The committee amendment would coordinate the SSI and social security (OASDI) benefit increases so that at the time the cost-of-living adjustment is made, the recipient's SSI benefit is based on his or her social security payment in the same month. Also, whenever the Secretary judges there to be reliable information on the recipient's income or resources in a given month, the SSI benefit in that month would be based on that information. The Secretary would be required to prescribe by regulation the circumstances in which such information could be used to determine the monthly SSI benefit.

This amendment would prevent SSI recipients from experiencing each year an unintended increase in total income above the cost-of-living adjustment followed two months later by an unexpected reduction in their benefits.

Effective date.—The cost-of-living coordination would be effective for benefits payable for months beginning 60 days after enactment. The broader authority would be effective on enactment.

Estimated savings.—

Fiscal years:	Millions
1933.....	\$45
1984.....	41
1985.....	43

PHASE OUT "HOLD HARMLESS" PROTECTION

(Section 184 of the Bill)

Present law.—SSI provides for a basic Federal minimum payment for all recipients. States are allowed to supplement the Federal payment. The original act of 1972 included "hold harmless" protection for the States which allowed them to supplement the Federal payment to assure that recipients would receive cash benefits equal to their January 1972 benefit levels, with no cost to the

State beyond what it spent for benefits on behalf of aged, blind and disabled persons in 1972.

Because of Federal benefit increases since that time, all except two States, Hawaii and Wisconsin, have lost their "hold harmless" status. These two States still receive a Federal contribution to their State supplements because of a special provision added to the law in 1976. Under this provision, their "hold harmless" payments are no longer reduced by Federal benefit increases.

The 1982 Continuing Resolution provided for a reduction in "hold harmless" payments for Wisconsin and Hawaii.

Committee amendment.—The committee amendment would continue phasing out "hold harmless" payments requiring hold harmless States to pay an increasing share of the cost of their supplementary benefits. These States would be required to pay 60 percent of the costs that would otherwise be paid by the Federal government in 1983, 80 percent in 1984, and 100 percent in 1985 and future years.

The committee believes that Federal hold harmless payments, now made to just two States, are no longer necessary for meeting the objectives of the initial SSI legislation of 1972. The original legislation, which required some State supplementation, was intended to assure that people receiving old-age assistance, aid to the blind, or aid to the permanently and totally disabled would not suffer a loss of income with the inception of the Federal SSI program, while protecting States from an increased fiscal liability due to caseload growth.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$30
1984.....	37
1985.....	45

RECOVERY OF SSI OVERPAYMENTS

(Section 185 of the Bill)

Present law.—The Secretary is required to recover SSI overpayments by adjusting future payments, or by recovery from the recipient. Recovery of overpayments is to be made with a view to avoiding penalizing the individual who is without fault. Recovery of overpayments is not required, for example, if the individual is without fault and if recovery would defeat the purpose of the program, or be against equity or good conscience, or the amount to be recovered is so small as to impede efficient or effective administration.

Committee amendment.—The committee amendment would, under these same conditions, allow recovery of SSI overpayments from benefits payable under other programs administered by the Social Security Administration (Black Lung and OASDI benefits).

Presently, 40-50 percent of SSI overpayments are not recovered mainly because the overpaid individuals are no longer eligible for SSI. Yet, about half of these overpaid SSI recipients continue to receive social security benefits from which the overpayments could be recovered.

The committee believes that in cases where individuals receive income support from SSI as well as from other programs administered by SSA, these other sources of income should be taken into account in overpayment recovery situations.

The committee understands that departmental regulations: (1) limit the reduction of SSI payments (in any one month) for the collection of overpayments so as to avoid leaving individuals totally without resources, and (2) provide that assistance payments will generally not be increased simply to replace income losses occasioned by reductions in benefits from other programs to collect overpayments. The committee expects that this provision will be administered in a similar manner. On the one hand, reductions should be made with due regard for the ongoing needs of the individual. On the other hand, it is not intended that SSI payments be increased to replace the social security or other benefits being withheld.

Effective date.—On enactment.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$16
1984.....	17
1985.....	18

G. PROVISIONS RELATED TO UNEMPLOYMENT COMPENSATION

(Subtitle G of Title I)

ROUND UNEMPLOYMENT BENEFITS TO NEXT LOWEST DOLLAR

(Section 191 of the Bill)

Present law.—Under present law the States may determine rounding procedures to apply in the calculation of an individual's weekly unemployment benefit.

Committee amendment.—The committee agreed to an amendment under which the Federal 50 percent matching share of extended unemployment benefits would not be available on that part of extended unemployment benefit payments which result from a failure on the part of the State to have a benefit structure in which benefits are rounded down to the next lower dollar.

This amendment would reduce Federal outlays while having only a minimal impact on future unemployment benefits.

Effective date.—This provision would be effective for benefits payable on or after October 1, 1983. States in which there is no legislative session prior to that date would, however, be given additional time before the provision would become effective.

Estimated savings.—

Fiscal years:	Millions
1983.....	\$0
1984.....	10
1985.....	19

IV. COSTS OF CARRYING OUT THE SPENDING REDUCTION PROVISION
OF THE BILL AND VOTE OF THE COMMITTEE

BUDGET EFFECTS

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., July 12, 1982.

Hon. ROBERT DOLE,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for certain provisions of H.R. 4961, a bill that would raise revenues and change Medicare, Medicaid and income security programs to reduce budget outlays as directed by the First Concurrent Resolution on the Budget for Fiscal Year 1983.

This estimate includes the revenue and spending effects of the proposed program changes to reduce budget outlays and the provisions relating to the Airport and Airway System Development Act. The budgetary effects of the revenue raising provisions will be addressed in a subsequent estimate. That estimate will include revenue and budget authority estimates of provisions such as the proposed increase in the federal unemployment tax and the proposed extension of Social Security hospital insurance taxes to federal employees.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

ALICE M. RAVLIN,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 4961 (excluding revenue raising provisions).
2. Bill title: Not available.
3. Bill status: As ordered reported by the Senate Committee on Finance on July 2, 1982.
4. Bill purpose. To make changes in the Medicare, Medicaid and income security programs to reduce budget outlays as directed by the First Concurrent Resolution on the Budget for Fiscal Year 1983. This bill also provides new direct spending authority from the Airport and Airway Trust Fund for grants-in-aid to airports and authorizes appropriations from the Trust Fund for certain other activities of the Federal Aviation Administration.

5. Cost estimate:

TABLE 1.—SUMMARY OF BUDGETARY EFFECTS OF H.R. 4961

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
a. Revenue changes.....		0	-80	-125	-140	-155	-180
b. Spending reductions (direct spending).....	BA	-142	-1,432	-1,973	-2,427	-3,112	-3,848
	O	0	-4,163	-5,897	-7,131	-9,189	-11,351
c. Spending increases (direct spending).....	BA	460	752	1,002	1,336	2,133	2,646
	O	0	185	468	611	772	1,054
d. Spending increases (authorizations).....	BA	26	2,635	3,233	3,283	3,230	3,058
	O	18	1,825	2,190	2,696	3,097	3,251
Total.....	BA	344	1,955	2,262	2,192	2,251	1,856
	O	18	-2,153	-3,239	-3,824	-5,320	-7,046

TABLE 2.—DETAILS OF BUDGETARY EFFECTS OF H.R. 4961

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
A. REVENUE CHANGES							
Modify coverage of working aged (medicare).....		0	-80	-125	-140	-155	-180
B. SPENDING REDUCTIONS (DIRECT SPENDING)							
Medicaid (function 550):							
Allow States to require nominal copayments on certain services.....	BA	-10	-32	-47	-53	-59	-65
	O	0	-42	-47	-53	-59	-65
Eliminate matching for medicare pt. B buy-in.....	BA	-49	-154	-216	-230	-242	-254
	O	0	-203	-216	-230	-242	-254
Allow States to apply liens.....	BA	-44	-139	-200	-221	-241	-263
	O	0	-183	-200	-221	-241	-263
Reduce error rate tolerances.....	BA	-7	-23	-65	-72	-80	-88
	O	0	-30	-65	-72	-80	-88
Impact of proposed medicaid legislation on current law penalties.....	BA	0	0	100	100	0	0
	O	0	0	100	100	0	0
Medicaid impact of AFDC proposals.....	BA	-25	-75	-130	-170	-190	-210
	O	0	-100	-130	-170	-190	-210
Medicaid impact of limiting reimbursement to hospitals in HI.....	BA	-7	-23	-80	-140	-150	-200
	O	0	-30	-80	-140	-150	-200
Total, medicaid.....	BA	-142	-446	-638	-786	-962	-1,080
	O	0	-588	-638	-786	-962	-1,080
Medicare (function 550):							
Delay initial eligibility date:							
Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-120	-155	-185	-210	-240
Medicare—SMI.....	BA	0	-19	-21	-25	-28	-30
	O	0	-50	-75	-85	-100	-110
Modify coverage of working aged:							
Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-250	-390	-430	-500	-570
Medicare—SMI.....	BA	0	-25	-30	-33	-38	-43
	O	0	-70	-100	-120	-130	-150
Require home health copayments: Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-35	-65	-75	-80	-85
PSRO: Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-15	-15	-20	-20	-25
Reduce reimbursement for radiology and pathology services: Medicare—SMI.....	BA	0	-53	-63	-70	-80	-91
	O	0	-160	-210	-250	-280	-320
Index part B deductible: Medicare—SMI.....	BA	0	-39	-64	-90	-121	-163
	O	0	-65	-155	-255	-360	-485
Limitation on economic index: Medicare—SMI.....	BA	0	-98	-115	-133	-153	-176
	O	0	-230	-390	-460	-530	-610
Repeal the routine nursing salary differential: Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-95	-110	-125	-145	-165
Impose salary equivalency test for hospital based physicians: Medicare—SMI.....	BA	0	-18	-21	-24	-27	-30
	O	0	-63	-73	-84	-96	-108
Hold pt. B premiums constant: SMI premiums—Offsetting receipts.....	BA	0	-36	-204	-499	-500	-1,400
	O	0	-36	-204	-499	-500	-1,400
Limit reimbursement to hospitals: Medicare—HI.....	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-610	-1,720	-3,120	-3,560	-4,590

TABLE 2.—DETAILS OF BUDGETARY EFFECTS OF H.R. 4961—Continued

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
Require medicare regulation:							
Eliminate private room subsidy:	BA	0	(1)	(1)	(1)	(1)	(1)
Medicare—HI.	O	0	-54	-75	-80	-85	-90
Establish single reimbursement limit	BA	0	(1)	(1)	(1)	(1)	(1)
for SNF and HHA services: Medi-	O	0	-18	-46	-46	-52	-58
care—HI.							
Eliminate duplicate payments of OP	BA	0	-56	-68	-81	-95	-111
services: Medicare—SMI.	O	0	-160	-225	-270	-325	-380
Increase funding for cost report audits:	BA	0	(1)	(1)	(1)	(1)	(1)
Medicare—HI.	O	0	-130	-300	-300	0	0
Temporarily delay PIP: Medicare—HI.	BA	0	(1)	(1)	(1)	(1)	(1)
	O	0	-750	-100	870	0	0
Modify reimbursement for assistants at	BA	0	-33	-38	-44	-49	-54
surgery: Medicare—SMI.	O	0	-55	-130	-150	-175	-195
Medicare payments to HMO's: Medicare.	BA	0	0	0	0	0	0
	O	0	0	0	0	0	0
Ineffective drug provision: Medicare.	BA	0	0	0	0	0	0
	O	0	0	0	0	0	0
Total, medicare.	BA	0	-377	-624	-999	-1,491	-2,098
	O	0	-2,966	-4,538	-5,684	-7,548	-9,581
Aid to families with dependent children							
(AFDC) (function 600):							
Round benefits.	BA	0	-9	-10	-10	-10	-10
	O	0	-9	-10	-10	-10	-10
Prorate first month's benefit.	BA	0	-13	-14	-14	-14	-14
	O	0	-13	-14	-14	-14	-14
Eliminate military service as basis for	BA	0	-15	-17	-17	-17	-18
eligibility.	O	0	-15	-17	-17	-17	-18
Sanction for refusal to work.	BA	0	-1	-1	-1	-1	-1
	O	0	-1	-1	-1	-1	-1
Mandate job search.	BA	0	-20	-50	-50	-50	-50
	O	0	-20	-50	-50	-50	-50
Eliminate parents' benefit when young-	BA	0	-47	-48	-48	-49	-50
est child reaches age 16.	O	0	-47	-48	-48	-49	-50
Include all minor children in AFDC unit.	BA	0	-63	-64	-64	-66	-67
	O	0	-63	-64	-64	-66	-67
Count income of unrelated adults.	BA	0	-69	-70	-70	-72	-73
	O	0	-69	-70	-70	-72	-73
Repeal emergency assistance.	BA	0	-60	-60	-60	-61	-61
	O	0	-60	-60	-60	-61	-61
Permit States to prorate shelter.	BA	0	-43	-44	-45	-46	-47
	O	0	-43	-44	-45	-46	-47
Reduce error rate tolerances.	BA	0	-85	-129	-41	-41	-41
	O	0	-85	-129	-41	-41	-41
Require minor parents to reside with	BA	0	-25	-27	-29	-32	-35
parents or guardians.	O	0	-25	-27	-29	-32	-35
Exclude certain State payments from in-	BA	0	0	0	0	0	0
come.	O	0	0	0	0	0	0
Extend time for establishment of WIN	BA	0	0	0	0	0	0
demonstrations.	O	0	0	0	0	0	0
Total, AFDC.	BA	0	-450	-534	-449	-459	-467
	O	0	-450	-534	-449	-459	-467
Supplemental security income (SSI) (function							
600):							
Prorate first month's benefit.	BA	0	-26	-28	-32	-36	-37
	O	0	-26	-28	-32	-36	-37
Round benefits.	BA	0	-20	-25	-30	-30	-30
	O	0	-20	-25	-30	-30	-30
Coordinate cost-of-living adjustments.	BA	0	-45	-41	-43	-42	-42
	O	0	-45	-41	-43	-42	-42
Phase out "hold harmless".	BA	0	-30	-37	-45	-45	-45
	O	0	-30	-37	-45	-45	-45
Recover overpayments.	BA	0	-16	-17	-18	-19	-20
	O	0	-16	-17	-18	-19	-20
Total, SSI.	BA	0	-137	-148	-168	-172	-174
	O	0	-137	-148	-168	-172	-174
Child support enforcement (function 600):							
Alter fee for non-AFDC families.	BA	0	-12	-16	-11	-13	-14
	O	0	-12	-16	-11	-13	-14
Assign wages for members of the armed	BA	0	-7	-9	-10	-10	-10
forces.	O	0	-7	-9	-10	-10	-10
Reimburse state agencies for ineligible	BA	0	-3	-4	-4	-5	-5
AFDC families.	O	0	-3	-4	-4	-5	-5
Total, child support.	BA	0	-22	-29	-25	-28	-29
	O	0	-22	-29	-25	-28	-29

TABLE 2.—DETAILS OF BUDGETARY EFFECTS OF H.R. 4961—Continued

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
Unemployment insurance (function 600).....	BA	0	0	0	0	0	0
	O	0	0	-10	-19	-20	-20
Total for provisions resulting in spending decreases.	BA	-142	-1,432	-1,973	-2,427	-3,112	-3,848
	O	0	-4,163	-5,897	-7,131	-9,187	-11,351
C. SPENDING INCREASES (DIRECT SPENDING)							
Airport and Airway System Development Act (function 400): Grants-in-aid to airports.	BA	450	600	600	600	1,049	1,207
	O	0	120	390	510	660	924
Medicaid (function 550):							
Allow states to continue medicaid eligibility for certain individuals.	BA	0	1	1	1	1	2
	O	0	1	1	1	1	2
Delay initial eligibility date in medicare.	BA	5	17	28	33	38	43
	O	0	22	28	33	38	43
Reduce reimbursement for radiology and pathology services in medicare.	BA	4	11	15	20	20	25
	O	0	15	15	20	20	25
Index pt. B deductible in medicare.....	BA	1	4	10	20	25	30
	O	0	5	10	20	25	30
Total, medicaid.....	BA	10	33	54	74	84	100
	O	0	43	54	74	84	100
Medicare (function 550):							
SMI premiums—Offsetting receipts.....	BA	0	22	24	27	28	30
	O	0	22	24	27	28	30
Judicial review.....	BA	0	(?)	(?)	(?)	(?)	(?)
	O	0	(?)	(?)	(?)	(?)	(?)
Increase in HI budget authority resulting from outlay savings:							
Delay initial eligibility date.....	BA	0	5	18	34	49	62
Modify coverage of working aged.....	BA	0	11	40	80	114	146
Require home health copayments.....	BA	0	2	6	13	18	23
PSRO.....	BA	0	1	2	4	5	6
Repeal the routine nursing salary differential	BA	0	5	15	25	35	45
Limit reimbursement to hospitals....	BA	0	30	135	370	640	920
Eliminate private room subsidy.....	BA	0	2	8	16	22	26
Establish single reimbursement limit for SNF and HHA services	BA	0	1	4	8	12	15
Increase funding for cost report audits	BA	0	6	25	54	62	53
Temporarily delay PIP.....	BA	0	34	71	31	15	13
Total HI budget authority.....	BA	0	97	324	635	972	1,309
	O	0	119	348	662	1,000	1,339
	O	0	22	24	27	28	30
Total for provisions resulting in spending increases (direct spending).	BA	460	752	1,002	1,336	2,133	2,646
	O	0	185	468	611	772	1,054
d. SPENDING INCREASES (AUTHORIZATIONS)							
Airport and Airway System Development Act (function 400):							
Facilities and equipment.....		251	725	1,393	1,407	1,377	1,164
Research, engineering and development.....		72	134	268	269	215	193
Operations.....		800	1,559	1,335	1,363	1,388	1,444
Weather services.....		0	27	29	31	33	35
Security screening.....		10	0	0	0	0	0
Total authorization.....		1,143	2,445	3,025	3,070	3,013	2,836
Less: Amounts already appropriated.....		1,117	0	0	0	0	0
Net additional authorization.....		26	2,445	3,025	3,070	3,013	2,836
Estimated outlays.....		18	1,635	1,982	2,483	2,880	3,029
Food stamps (function 600): Impact of AFDC and SSI proposals:							
Estimated authorization.....		0	190	208	213	217	222
Estimated outlays.....		0	190	208	213	217	222
Total for provisions resulting in spending increases (authorizations):							
Authorization.....		26	2,635	3,233	3,283	3,230	3,058
Outlays.....		18	1,825	2,190	2,696	3,097	3,251
Total:							
Authorization/budget authority.....		344	1,955	2,262	2,192	2,251	1,856
Outlays.....		18	-2,153	-3,239	-3,824	-5,320	-7,046

¹ Budget authority shown under spending increases.² Less than \$1,000,000.

Some sections in this bill would reduce future federal liabilities through changes to existing entitlements and therefore could permit subsequent appropriations' actions to reduce the budget authority for these programs. The figures shown as "Budget Authority" (BA) represent those amounts by which budget authority could be reduced, as a result of this bill, below the levels needed under current law.

6. Basis of estimate: The savings shown for this bill are estimated based on draft legislation. Detail on the bases of the estimates is available from CBO staff.

Certain proposed changes in some programs cause outlays in other programs to change. For example, reductions in benefits to recipients in the AFDC program cause outlays in the Food Stamp program to increase. Most AFDC recipients receive food stamps and the amount of a recipient family's food stamp benefit depends on the family's income. In addition, when changes in the AFDC program make families ineligible for AFDC, they often lose Medicaid benefits, causing Medicaid outlays to decrease. Such changes in outlays are shown in the cost estimate table. In the case of Food Stamps, such increases are relative to CBO's baseline estimates that assume continuation of the current program.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Thomas Buchberger, Hinda Ripps Chai-kind, Malcolm Curtis, Richard Hendrix, Marilyn Moon, Janice Peskin, Lisa Potetz, Charles Seagrave, Robert Sunshine.

10. Estimate approved by:

C. G. NUCKOLS
(For James L. Blum,
Assistant Director for Budget Analysis).

VOTE OF THE COMMITTEE

In compliance with section 133 of the Legislative Reorganization Act of 1946, the committee states that the spending reduction provisions of the bill were ordered favorably reported by a vote of 13 ayes and 6 nays.

V. REGULATORY IMPACT OF THE SPENDING REDUCTION PROVISIONS

SECTIONS A-C—HEALTH PROVISIONS

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee states that the provisions of the bill related to Medicare, Medicaid, and Utilization and Quality Control Peer Review will not impact on the personal privacy of individuals.

In implementing certain cost saving provisions of the bill there will be some increase in Federal regulatory activity. It is not anticipated, however, that the legislation would impose an unusual or burdensome regulatory effect. Several provisions will, in fact, decrease regulatory activity and associated paperwork.

Four provisions related to Medicare (sections 107, 115, 116, and 118) and two related to Medicaid (sections 132 and 135) are expected to decrease regulatory activity and associated paperwork. Ten medicare provisions, two Medicaid provisions, and the utilization and quality control provision will impose a minimal regulatory effect. Five medicare provisions (sections 102, 108, 110, 114, and 120) and one Medicaid provision (section 133) will require the promulgation of new regulations in order to implement these significant changes in program policy. The paperwork associated with these six provisions will be significant but is not expected to be burdensome.

SECTIONS D-G—INCOME SECURITY

D. Aid to Families With Dependent Children

Sections 151–154, 158 and 161–162 are expected to have, at most, a minimal impact on regulatory burden and paperwork for States. Sections 154–156, 159 and 160 will place an increased regulatory, financial, and paperwork burden on States complying with these provisions. It is not anticipated, however, that these provisions would impose an unusual or burdensome regulatory impact. Sections 155, 156, 158, and 160 would impose greater reporting requirements on recipients seeking to comply with federal law and regulation. A number of the provisions would have economic impacts on certain recipients in the form of lower benefit amounts (sections 150, 151, 156–158) or benefits that would not be paid because eligibility requirements would no longer be met (sections 153–156, 160).

E. Child Support Enforcement

Section 171 of the title E would decrease the Federal regulatory burden and resulting paperwork for State agencies by repealing a provision in current law which States have reported difficult to implement because of legislative barriers and administrative difficulties.

Section 172 would increase Federal regulatory activity and paperwork, but only minimally. Section 173 would decrease the regulatory and financial burden on States.

F. Supplemental Security Income

Sections 181, 182, 184 and 185 of title F are expected to have, at most, only a minimal impact on Federal regulatory activity. Section 183 should reduce the Federal regulatory, financial, and paperwork burden by correcting a flaw in current law and ensuring that SSI accounting procedures operate more efficiently. Sections 181 and 182 would have a relatively minor economic impact on recipients resulting in slightly lower future benefit amounts.

G. Unemployment Compensation

Section 191 of title G is not expected to place any significant Federal regulatory burden on the States. It may result in slightly lower benefit amounts if States choose to incorporate this provision into their laws.

The bill also provides for reduction of employment tax liabilities in situations involving the reclassification of workers as employees and provides for Tax Court jurisdiction over employment tax disputes.

This provision reduces fiscal year receipts by \$0.2 billion in 1983 and \$0.1 billion in 1984, and increase receipts by \$0.1 billion in 1985.

Federal unemployment tax

The bill modifies the Federal employment insurance tax to reduce the deficits of the unemployment insurance program. Effective January 1, 1983, the FUTA wage base is increased to \$7,000 and the tax rate is increased to 3.5 percent. Effective January 1, 1985, the Federal tax rate is increased to 6.2 percent (a permanent tax of 6.0 percent and an extended benefit tax of 0.2 percent) and the credit which employers receive against the tax is increased to 5.4 percent. The progressive reduction of the FUTA credit applicable to States in default is retained as under current law.

This provision will increase revenues by \$1.4 billion in fiscal year 1983, \$2.4 billion in 1984, and \$2.9 billion in 1985.

Extension of Social Security hospital insurance taxes and medicare coverage to Federal employees

Most Federal employees eventually qualify for medicare; however, they are currently exempt from the medicare tax. Under the bill, Federal employees will be subject to the FICA hospital insurance tax. (The tax is imposed at the rate of 1.3 percent of wages received during 1982-1984, 1.35 percent of wages received during 1985, and 1.45 percent of wages received after December 31, 1985.) Federal employees will also receive medicare coverage after paying hospital insurance taxes for the required period of time.

This provision will increase revenues by \$0.6 billion in fiscal year 1983, \$0.8 billion in 1984, and \$0.9 billion in 1985.

Excise Tax Provisions

Airport and airway tax measures

Under present law, no tax revenues are being transferred to the Airport and Airway Trust Fund. Under the bill, the following aviation excise taxes are designated for the Trust Fund: (1) an 8-percent passenger ticket tax (increased from the present 5-percent rate); (2) a 12-cents-per-gallon tax on noncommercial aviation gasoline (increased from the present 4-cent rate); (3) a 14-cents-per-gallon tax on nongasoline fuels for noncommercial aviation (no tax under present law); (4) a 5-percent air freight waybill tax (no tax under present law); (5) a \$3 per person international departure ticket tax (no tax under present law); and (6) amounts equal to revenues from the present taxes on aircraft tires and tubes. Certain helicopters engaged in natural resources and timber operations not using Federal-aid or Federal facilities will be exempt from the fuel taxes. The tax changes apply to tickets and to fuels purchased after August 31, 1982.

The aviation tax provisions will increase revenues by \$0.8 billion in fiscal year 1983, \$1.0 billion in 1984, and \$1.1 billion in 1985.

In addition, the committee approved a separate provision (title IV) regarding the Airport and Airway System Development Act which would: (1) authorize expenditures for certain capital improvements to

2. Federal unemployment tax (FUTA) provisions (sec. 275 of the bill, secs. 3301, 3302, 3306, and 6157 of the Code, and sec. 901 of the Social Security Act)

Present Law

Under the Federal Unemployment Tax Act (FUTA), employers are subject to a payroll tax of 3.4 percent on the first \$6,000 of wages per employee per year. If a State unemployment insurance law meets the requirements of Federal law, employers in that State generally receive a 2.7 percent credit against the Federal tax, for a net Federal tax of 0.7 percent. The net effective Federal tax rate will automatically drop by 0.2 percent (to 0.5 percent) when the general fund of the Treasury is repaid the outstanding loans made to the extended benefit account.

States also levy unemployment compensation taxes in order to finance benefit payments. Almost all jurisdictions determine an employer's tax rate under a system of experience rating in which the tax rate depends on total unemployment benefits recently paid to an employer's former employees. Federal law requires that no reduced rate (usually a rate below 2.7 percent) may be assigned to an employer except on the basis of the employer's experience rating.

Both the State and Federal taxes are part of the Federal budget and are deposited in the Federal Unemployment Trust Fund. State tax revenues are used to pay regular State benefits and one-half of the cost of extended benefits. Federal tax revenues are used for State and Federal administrative costs and the remaining half of the cost of extended benefits, and to maintain a loan fund from which a State may borrow when it lacks funds to pay State benefits.

Reasons for Change

The unemployment program is seriously underfinanced. Recessions of the 1970s and inadequate State and Federal funding have led to substantial deficits currently being financed through Trust Fund borrowing from the Federal Treasury. Outstanding borrowing from the Treasury was equal to \$13.1 billion at the end of fiscal year 1981. Total State debt to the Trust Fund is expected to increase in 1982 because of additional State borrowing.

The taxable Federal wage base has not been increased since 1978, thus Federal revenues have not kept up with the increases since that year in benefit and administrative costs.

Explanation of Provision

Effective January 1, 1983, the Federal unemployment tax (FUTA) wage base would increase to \$7,000 and the tax rate will be raised to 3.5 percent, thus increasing the net effective Federal tax

rate from 0.7 to 0.8 percent. In States which now have a taxable wage base below \$7,000 and which automatically conform their wage base to the Federal base, this change will also result in an increase (to \$7,000) in the taxable wage base for State unemployment taxes.

Effective January 1, 1985 the Federal tax rate will increase to 6.2 percent (a permanent tax of 6.0 percent and an extended benefit tax of 0.2 percent), and the credit will be increased to 5.4 percent. This change does not affect the net Federal tax rate, which remains at 0.8 percent. It does, however, increase the standard State tax rate from 2.7 to 5.4 percent. This means that States allowing reduced rates below 5.4 percent will have to do so on an experience rating basis.

Under present law, the Federal tax credit may, subject to certain limitations, be reduced for employers in States which have borrowed and not repaid funds to meet shortfalls in their unemployment accounts. In general, these credit reductions, when applicable, begin at a rate of 0.3 percent per year and increase at a rate of 0.3 percent per year, subject to certain limitations. This provision is not changed in any way under the bill.

Effective Date

The increase in the wage base to \$7,000 and the increase in the rate to 3.5 percent are effective for wages paid after December 31, 1982. The increase in the tax rate to 6.2 percent and the increase in the credit rate to 5.4 percent are effective for wages paid after December 31, 1984.

Revenue Effect

This provision increases fiscal year budget receipts by \$1,404 million in 1983, \$2,353 million in 1984, \$2,856 million in 1985, \$2,818 million in 1986, and \$2,554 million in 1987.

3. Extension of Social Security Hospital Insurance Taxes and Medicare coverage to Federal employees (sec. 276 of the bill, secs. 3101 and 3111 of the Code, and secs. 213, 226, 226A, and 1811 of the Social Security Act)

Present Law

Under current law, entitlement to protection under the Hospital Insurance or Part A portion of the Medicare program for most individuals is linked to entitlement to monthly social security retirement or survivor benefits or to railroad retirement benefits. This entitlement is earned through work in employment covered by the social security or railroad retirement system. Workers help finance the costs of hospital insurance benefits by payment of the hospital insurance tax (currently 1.3 percent) on wages subject to social security taxation. Present law excludes certain kinds of employment from the social security system and from paying social security taxes, including Federal civilian employment that is covered under a staff retirement system established by a law of the United States. Regular Federal employees, including postal workers, are covered under such retirement systems. They pay no Hospital Insurance taxes, nor do they become entitled to Hospital Insurance benefits on the basis of such employment.

Reasons for Change

Many active Federal civilian employees have worked long enough (or their spouses have) in employment covered by social security to become insured under the Hospital Insurance program. However, while most workers in covered social security employment are subject to the Hospital Insurance tax throughout their entire working careers, Federal employees may earn the same coverage with relatively fewer years of work subject to the tax. The committee believes that Federal workers should bear a more equitable share of the costs of financing the benefits to which many of them eventually become entitled.

The bill, therefore, extends Medicare coverage to all members of the Federal workforce in the same way coverage is provided to most other workers. Federal employees will earn equivalent quarters of coverage for Hospital Insurance by paying the HI tax on their wages. Employees earning 40 or more quarters of coverage from work in Federal employment or in any combination of Federal and other employment subject to the HI tax would qualify for Hospital Insurance benefits just as other workers now do. Federal employees nearing retirement would be grandfathered in with reduced quarters of coverage requirements.

Explanation of Provision

The committee bill subjects Federal employees, including postal workers, to the Hospital Insurance tax, and will entitle individuals who have been Federal employees and who reach age 65 years of age, suffer from end-stage renal disease, or become disabled to Medicare Hospital Insurance after paying Hospital Insurance taxes for the same number of years (usually 10) that is required of most other workers. Individuals who have attained age 57 by 1983 and who are Federal employees on January 1, 1983, would have a reduced number of additional years of employment required (with no additional years required for those who have attained age 65 by 1983) for purposes of determining their eligibility for Medicare benefits.

Effective Date

The provision is effective on January 1, 1983.

Revenue Effect

This provision will increase fiscal year receipts by \$617 million in 1983, \$837 million in 1984, \$927 million in 1985, \$1,066 million in 1986 and \$1,163 million in 1987. Outlays will be increased by approximately \$25 million in fiscal year 1983, \$50 million in 1984, and \$75 million in 1985.

97TH CONGRESS }
2d Session }

SENATE

{ REPT. 97-494
Vol. 2 }

**TAX EQUITY AND FISCAL RESPONSIBILITY
ACT OF 1982**

REPORT
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON
H.R. 4961
together with
ADDITIONAL SUPPLEMENTAL AND MINORITY VIEWS



JULY 12, 1982.—Ordered to be printed

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No material relating to the Social Security Act in Volume 2.

TAX EQUITY AND FISCAL RESPONSIBILITY
ACT OF 1982

CONFERENCE REPORT

TO ACCOMPANY

H.R. 4961



AUGUST 17, 1982.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

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TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

AUGUST 17, 1982.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4961]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4961) to make miscellaneous changes in the tax laws, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. *SHORT TITLE; TABLE OF CONTENTS; AMENDMENT OF 1954 CODE.*

(a) *SHORT TITLE.*—*This Act may be cited as the "Tax Equity and Fiscal Responsibility Act of 1982".*

(b) *TABLE OF CONTENTS.*—

Sec. 1. Short title; table of contents; amendment of 1954 Code.

TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

Subtitle A—Medicare

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- Sec. 101. Payment for inpatient hospital services.*
- Sec. 102. Single reimbursement limit for skilled nursing facilities.*
- Sec. 103. Elimination of inpatient routine nursing salary cost differential.*
- Sec. 104. Elimination of duplicate overhead payments for outpatient services.*
- Sec. 105. Single reimbursement limit for home health agencies.*
- Sec. 106. Prohibiting payment for Hill-Burton free care.*
- Sec. 107. Prohibiting payment for anti-unionization activities.*

- Sec. 108. Reimbursement of provider-based physicians.*
- Sec. 109. Prohibiting recognition of payments under certain percentage arrangements.*
- Sec. 110. Elimination of lesser-of-cost-or-charge provision.*
- Sec. 111. Elimination of private room subsidy.*

Subpart B—Payments for Other Services

- Sec. 112. Reimbursement for inpatient radiology and pathology services.*
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- Sec. 114. Payments to health maintenance organizations and competitive medical plans.*
- Sec. 115. Prohibition of payment for ineffective drugs.*

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- Sec. 116. Medicare payments secondary for older workers covered under group health plans.*
- Sec. 117. Interest charges on overpayments and underpayments.*
- Sec. 118. Audit and medical claims review.*
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- Sec. 120. Temporary delay in periodic interim payments.*

PART II—CHANGES IN BENEFITS, PREMIUMS, AND ENROLLMENT

- Sec. 121. Medicare coverage of Federal employees.*
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- Sec. 135. Six-month moratorium on deregulation of skilled nursing and intermediate care facilities.*
- Sec. 136. Medicaid program in American Samoa.*
- Sec. 137. Technical corrections from Omnibus Budget Reconciliation Act of 1981.*

Subtitle C—Utilization and Quality Control Peer Review

- Sec. 141. Short title of subtitle.*
- Sec. 142. Requirement for Secretary to enter into contracts.*
- Sec. 143. Establishment of utilization and quality control peer review program.*
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- Sec. 145. Waiver of liability provision.*
- Sec. 146. Medicaid provisions.*
- Sec. 147. Demonstration projects for competitive bidding and other reimbursement methods.*
- Sec. 148. Technical amendments.*
- Sec. 149. Effective date.*
- Sec. 150. Maintenance of current PSRO agreements.*

Subtitle D—Aid to Families with Dependent Children

- Sec. 151. Rounding of eligibility and benefit amounts.*
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- Sec. 155. Proration of standard amount for shelter and utilities.*

- Sec. 156. Limitation of Federal financial participation in erroneous assistance expenditures.
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- Sec. 161. Delayed effective date in cases requiring conforming State legislation.

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- Sec. 171. Fee for services to non-AFDC families.
- Sec. 172. Allotments from pay for child and spousal support owed by members of the uniformed services on active duty.
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- Sec. 181. Effective date of application; proration of initial SSI benefit payment.
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- Sec. 506. Airway improvement program.*
- Sec. 507. Apportionment of funds.*
- Sec. 508. Use of apportioned and discretionary funds; miscellaneous conditions.*
- Sec. 509. Submission and approval of project grant applications.*
- Sec. 510. United States share of project costs.*
- Sec. 511. Project sponsorship.*
- Sec. 512. Grant agreements.*
- Sec. 513. Project costs.*
- Sec. 514. Payments under grant agreements.*
- Sec. 515. Performance of construction work.*
- Sec. 516. Use of Government-owned lands.*
- Sec. 517. False statements.*
- Sec. 518. Access to records.*
- Sec. 519. General powers.*
- Sec. 520. Civil rights.*
- Sec. 521. Reports to Congress.*
- Sec. 522. Report on ability of airports to finance airport development needs.*
- Sec. 523. Repeals; effective date; saving provisions; and separability.*
- Sec. 524. Miscellaneous amendments.*
- Sec. 525. Safety certification of airports.*
- Sec. 526. Contracting authority.*
- Sec. 527. Study of airport access.*
- Sec. 528. Part-time operation of flight service stations.*
- Sec. 529. Explosive detection K-9 teams.*
- Sec. 530. Release of certain conditions.*
- Sec. 531. Continuation of certain certificates.*
- Sec. 532. State taxation.*

TITLE VI—FEDERAL SUPPLEMENTAL COMPENSATION PROGRAM

Subtitle A—Extension of Benefits

- Sec. 601. Short title.*
- Sec. 602. Federal-State agreements.*
- Sec. 603. Payments to States having agreements for the payment of Federal supplemental compensation.*
- Sec. 604. Financing provisions.*
- Sec. 605. Definitions.*
- Sec. 606. Fraud and overpayments.*

Subtitle B—Taxation of Unemployed Compensation

- Sec. 611. Taxation of unemployment compensation.*

(c) *AMENDMENT OF 1954 CODE.*—Except as otherwise expressly provided, whenever in titles II, III, and IV an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954.

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TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

SUBTITLE A—MEDICARE

1. One month delay in entitlement to medicare benefits

Senate amendment

The Senate amendment defers eligibility for parts A and B of medicare until the first day of the month following the month in which an individual attains age 65.

The provision would be effective with respect to individuals reaching age 65 after August 1982.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

2. Medicare payments secondary for older workers choosing to remain covered under group health plans

Senate amendment

The Senate provision amends the Federal Age Discrimination in Employment Act (ADEA) to require employers to offer their employees age 65 through 69 and their dependents the same health benefits as are offered to their younger employees. The provision makes medicare the secondary payor for such employees (and their spouses) age 65 through 69. The provision would not apply to employees with less than 20 employees.

Medicare's payment for any item or service furnished to an employee (or his or her spouse) would be reduced where the combined payment under medicare and the employer's health benefits plan would otherwise exceed an amount equal to: (1) for items or services reimbursed on a cost or cost-related basis, their reasonable cost; or, (2) for items reimbursed on a charge basis, the higher of the reasonable charge (or other amount payable under medicare, without regard to the program deductibles or coinsurance) or the amount payable under the employer group plan (without regard to deductibles or coinsurance imposed under that plan). In no case would medicare pay more than medicare would have paid in the absence of any employer plan coverage. This provision would be effective January 1, 1983.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment. It is the intent of the conferees that an employee will have the option of rejecting the plan offered by the employer, thereby, retaining medicare as primary coverage. It is the understanding of the conferees that the Secretary of Labor will promulgate regulations to prevent

employers from offering a group health insurance plan or option which is designed to circumvent this provision in an attempt to induce employees to reject the employer general health benefit plan offered to other employees under the age of 65.

3. Five-percent copayments for home health services

Senate amendment

The Senate amendment imposes copayments on home health services equal to 5 percent of the average reasonable cost per visit, beginning with the twentieth visit made with respect to an individual in a calendar year. The provision would be effective with respect to services furnished on or after January 1, 1983.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

4. Reimbursement for inpatient radiology and pathology services

Senate amendment

The Senate amendment eliminates the 100 percent reimbursement rate currently applicable to services provided to hospital inpatients that are furnished by radiologists and pathologists who accept assignment in all cases for these services. Thus, medicare will pay for such services on the same basis as for other physicians' services, i.e. 80 percent of the reasonable charge after the part B deductible has been met. The provision is effective with respect to services furnished on or after October 1, 1982.

House committee provision

Same provision.

Conference agreement

The conference agreement includes the Senate amendment.

5. Increase in part B deductible

Senate amendment

The Senate amendment increases the Part B deductible for calendar year 1984 to \$78 and for 1985 and subsequent calendar years to \$80.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

6. Limitation on physician fee economic index

Senate amendment

The Senate amendment provides that (1) the increase in the physician economic index effective July 1, 1982 would not be in effect for charges for services rendered on or after October 1, 1982; (2) the increase allowed for the 12-month period beginning July 1, 1983 could not exceed five percent; and (3) the Secretary of the Department of Health and Human Services would be required to report to the Congress changes in the rate of assignment and in costs paid by beneficiaries as a result of changes made in physician reimbursement.

House committee provision

Under the House committee provision (1) the increase in the economic index for prevailing fees effective July 1, 1982 would be reduced to 4 percent effective October 1, 1982; (2) physicians who agree to accept assignment on all their bills would not be subject to this reduction; and (3) the date of the annual update in the customary and prevailing charge screens would be delayed from July 1, until October 1 of each year, starting in 1983.

Conference agreement

The conference agreement does not include either provision.

7. Elimination of inpatient routine nursing salary cost differential

Senate amendment

The Senate amendment eliminates the routine nursing salary cost differential paid to hospitals and skilled nursing facilities. The provision would be effective October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment.

8. Reimbursement of provider-based physicians

Senate amendment

The Senate amendment directs the Secretary to prescribe regulations, effective no later than October 1, 1982, which will distinguish between (1) professional medical services which require performance of the physician in person; which are personally rendered to individual patients; which contribute to the patients' diagnosis and treatment; and are reimbursable only under part B on a charge basis, and (2) the professional medical services of practitioners which are of benefit to patients generally and other services not discussed in (1) above which can be reimbursed only on a reasonable cost basis. The amendment provides that reasonable cost reimbursement for provider-based services cannot exceed a reasonable compensation equivalent which shall be established by the Secretary in regulations and shall be based on reasonable annual com-

pensation levels for a full-time equivalent practice in the specialty involved, or on such other basis as the Secretary may approve.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment with minor modifications. The agreement directs the Secretary to prescribe regulations which will distinguish between (1) professional medical services which are personally rendered to an individual patient, which contribute to the patient's diagnosis or treatment, and are reimbursable only under part B on a charge basis; and (2) professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Reasonable cost reimbursement for provider-based services could not exceed a reasonable compensation equivalent established by the Secretary in regulations. The conference agreement directs that regulations implementing this provision be published and effective by October 1, 1982. The conferees understand that such regulations are already under preparation by HHS. The publication and timely implementation of these regulations would reflect the intent of the conferees.

9. Part B premium as a constant percentage of costs

Senate amendment

The Senate amendment would suspend the current limitation on annual increases in the part B premium and instead increase the premium on October 1, 1982, on July 1, 1983, and on July 1, 1984 to a level which will result in monthly premiums which are in the aggregate equal to 25 percent of program costs for aged beneficiaries. During this period, premium increases would not be limited to the lower of the percentage by which cash social security benefits most recently increased, or the increase in the costs of the program as is required by present law. The present law limitation and method of calculating premiums would resume on July 1, 1985.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment with a modification allowing no premium increase before July 1, 1983.

10. Medicare reimbursement to hospitals

(A) EXPANSION OF SECTION 223 LIMITS TO INCLUDE ANCILLARY COSTS

Senate amendment

The Senate amendment extends the so-called Section 223 limitation of present law to ancillary service operating costs, effective with hospital cost reporting periods beginning on or after October 1, 1982. The new limitation would be applied on an average cost-per-case basis and each hospital's limit would be modified by a

case-mix adjustment. In no case would payment on a cost-per-case basis be reduced below the allowable cost-per-case reimbursement for the hospital's cost reporting period that immediately precedes the first cost reporting period to which the new limitation is applicable. The limitation would be set at 110 percent of the mean for hospitals of the same type. The Secretary would be required to provide appropriate exemptions, exceptions and adjustments including an adjustment for the special needs of hospitals that incur additional costs in treating low-income patients. Rural hospitals with less than 50 beds would be exempted from the limitations.

House committee provision

The House committee provision is similar to the Senate amendment except that the limitation would be set at 120 percent of the mean in fiscal year 1983, and the Secretary would be authorized to reduce the limitation to 115 percent in fiscal year 1984 and to 110 percent in fiscal year 1985. Provisions similar to those in the Senate amendment are included regarding exemptions, exceptions and adjustments, except that the House provision specifically requires appropriate adjustments for the special needs of psychiatric hospitals and hospitals serving a significantly disproportionate number of low-income or medicare patients. Hospitals in operation with less than 50 beds, on the date of enactment, would be exempted from the limitation without regard to location.

Conference agreement

The conference agreement follows the Senate amendment, under which the current Section 223 limitation would be extended to include ancillary service operating costs, applied on an average cost-per-case basis, and adjusted for case-mix, effective with cost reporting periods beginning on or after October 1, 1982. In no case would reimbursement on a cost-per-case basis be reduced below the allowable cost-per-case reimbursement for the hospital's cost reporting period that immediately precedes the first cost reporting period to which the new limitation is applicable. Under the conference agreement, for the first reporting period it becomes effective, the new limitation would be set at 120 percent of the mean for hospitals of the same type; for the second year, the limitation would be 115 percent of the mean; and for the third and subsequent years, the limitation would be 110 percent of the mean.

Appropriate adjustments would be required for the special needs of psychiatric hospitals and hospitals serving a significantly disproportionate number of low-income or medicare patients. Non-SMSA hospitals with less than 50 beds would be excluded. Other appropriate exemptions, exceptions, and adjustments would be required as in the Senate provision including an adjustment to assure that the proposed limits would not be significantly compromised if a hospital reduces its costs by cutting back on the kinds of services it provides directly to its patients (e.g., leasing its clinical laboratory).

The Secretary is expected to recalculate case-mix adjustments periodically. It is understood that initially the Secretary will need to rely on a currently available indicator of case-mix complexity such as the system developed at Yale University. It is expected that the Secretary will continue to evaluate possible methods for adjusting

for case-mix and will adopt an improved method when it becomes available.

It is recognized that case-mix adjusted hospital cost data will not be available on a fully current basis, and must be updated to the hospital cost reporting period for which it will be used in establishing limits. It is expected that the Secretary will use estimated actual industry-wide cost increase data to update available data on hospital costs to the cost reporting period to which the limit will be applied; a further adjustment for anticipated cost increases during the year subject to limits will be based on a hospital wage and price index plus one percentage point.

(B) THREE-YEAR HOSPITAL RATE OF INCREASE PROVISION

Senate amendment

The Senate amendment places an overall limit on annual increases in a hospital's medicare reimbursement on a per case basis, effective for three hospital reporting periods beginning with hospital cost reporting periods beginning on or after October 1, 1982. For the first 2 cost reporting periods, hospitals would be paid 25 percent of their costs in excess of their limits, but none of the excess would be reimbursed in the third year.

The maximum allowable increase is the previous year's allowable costs (or, after the first year, the previous year's limitation ceiling amount) increased by the percentage increase in the hospital wage and price index plus 2 percentage points.

The Secretary is required to provide for exemptions, exceptions, and adjustments from the limits in cases where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, distort the hospital's increase in costs.

House committee provision

The House committee provision establishes a target reimbursement system under which hospitals with operating costs (per case) below the target rate would be paid their costs plus a bonus of 50 percent of the savings (but not to exceed 5 percent of the target rate), and hospitals with costs above the target rate would be paid 50 percent of excess costs (up to 105 percent of target), 25 percent of excess costs (between 105 and 110 percent of target) and none of costs above 110 percent of target. These payments are subject to Section 223 limitations.

The target rate is the previous year's allowable costs (or, after the first year, the previous year's target amount) increased by the percentage increase in the hospital wage and price index plus 1 percentage point.

The Secretary is authorized to provide appropriate exceptions and adjustments to the target rate, specifically including an adjustment for psychiatric hospitals.

The target system applies to reimbursement in the Federal fiscal years 1983, 1984, and 1985, regardless of the period covered by the individual hospital's fiscal year, but ceases upon implementation of a prospective payment system.

Conference agreement

Under the conference agreement, a target rate reimbursement system would be established applicable to a hospital's first three cost reporting periods beginning on or after October 1, 1982. Under the provision, the target rate would be the previous year's allowable operating costs per case (or, after the first year, the previous year's target amount) increased by the percentage increase in the hospital wage and price index plus one percentage point. A hospital with operating costs below the target rate would be paid its costs plus a bonus of 50 percent of the savings (but not to exceed 5 percent of the target rate); a hospital with costs above the target rate would be allowed 25 percent of its cost in excess of the target for the first 2 years; none of the excess would be reimbursed in the third year. Provider payments under the target reimbursement system could not exceed the amount payable under the new section 223 limitations.

The Secretary of HHS would be required to provide for appropriate exemptions, exceptions, and adjustments as in the Senate provision. The conferees note that adjustments could have the effect of either increasing or decreasing the target payment amount. The principal intention in authorizing such adjustments is to take into account factors that would distort either a hospital's base period or rate of cost increase in any of the three years to which the provisions are applicable. Examples of such factors include significant changes in a hospital's case-mix in a particular year when compared to the base year, extraordinary circumstances beyond the hospital's control, and a reduction in a hospital's costs resulting from cutting back on the kinds of services directly provided to patients—e.g., as the result of leasing out its clinical laboratory.

Because the proposed target rates of increase and the new section 223 limits would be determined on a per case basis, an incentive would be created to increase admissions or discharges. It is anticipated that the Secretary will give consideration to making an adjustment where a hospital manipulates admissions or discharges in order to maximize reimbursement.

Because both the new limitation on total inpatient operating costs (the expanded section 223 limitations) and the target reimbursement provisions begin as early as October 1, 1982 for hospitals with cost reporting periods beginning on that date, it is recognized that the Secretary will have limited time to prepare for implementation of these new reimbursement provisions. Accordingly, the conference agreement authorizes the Secretary to proceed to implementation on the basis of final regulations issued without the customary prior comment period. However, it is expected that comments on the final regulations will be solicited and that appropriate revisions will be made based on the comments received.

Similarly, time may not permit the normal process of approval of forms to take place under the provisions of the Paperwork Reduction Act of 1980 (P.L. 96-511). Accordingly, all revisions to the medicare cost reporting forms necessary to implement these new reimbursement provisions would be exempt from the Act until the end of calendar year 1983, after which it is expected that the Pa-

perwork Reduction Act will be complied with in the normal manner.

In the case of hospitals currently under the OASDHI program which withdraw after August 15, 1982, the Secretary of HHS is required to compute a reduction in the amount of payments otherwise made to reflect the savings in costs achieved through withdrawals. This reduction can be offset by demonstrated expenditures for pension, health, and insurance benefits which are comparable to, and substituted for, the Social Security benefits.

(C) PROSPECTIVE PAYMENTS FOR HOSPITALS AND SKILLED NURSING FACILITIES

Senate amendment

The Senate amendment requires the Secretary to develop, in consultation with Senate Finance Committee and House Ways and Means Committee, medicare prospective reimbursement proposals for hospitals, skilled nursing facilities and to the extent feasible other providers, and to report to the committees on the proposals within 5 months.

House committee provision

The House committee provision requires the Secretary to develop and to submit to Congress by December 31, 1982, a medicare prospective payment plan for hospital inpatient services and extended care services designed to take effect October 1, 1983, and which, if implemented would not result in any increase in program costs. If submitted on a timely basis, the plan would take effect and replace reimbursement policy under existing law unless disapproved by concurrent resolution of Congress adopted by July 1, 1983.

Conference agreement

The conferees agreed to the Senate provision. Because of the desire of the conferees to proceed as soon as possible with a prospective payment system, it is expected that the administration recommendations, when presented to the Finance Committee and Committee on Ways and Means, will be sufficiently detailed as to be able to serve as a basis for legislation.

(D) RECOGNITION OF STATE HOSPITAL COST CONTROL SYSTEMS

Senate amendment

No provision.

House committee provision

Under the House committee provision, the Secretary would be authorized, at his discretion, to permit payment under an alternative reimbursement system if, upon application by the State, the Secretary determined that (1) the system would apply to substantially all non-Federal acute care hospitals in the State and would apply to the review of at least 75 percent of all revenues or expenses for inpatient hospital services including medicare and medicaid; (2) the Secretary has been provided satisfactory assurances regarding the equitable treatment of all entities that pay hospitals

for inpatient services (including medicare and medicaid), together with assurances regarding the equitable treatment of hospital employees and patients; and (3) the Secretary has been provided satisfactory assurances that under the system, over a 36-month period, the amount of payments made under the proposed alternative reimbursement system would not be greater than the amount of payments which would otherwise have been made under medicare. In determining whether an alternative system would result in reimbursement which is less than otherwise would have been paid in a State, the Secretary would be permitted to take into account previous reductions in medicare reimbursement due to the operation of a hospital reimbursement control system if such system has resulted in an aggregate rate of increase in operating costs of inpatient services under medicare which was less than the national aggregate rate of increase in such costs.

Conference agreement

The conference agreement included the House committee provision with a modification with respect to the termination of current medicare waivers. The conferees included the House committee provision to allow the Secretary to take advantage of effective alternative reimbursement systems which have already been implemented or those which may be implemented in the future. Although the provision provides discretion to the Secretary in approving alternative state systems, the conferees expect the Secretary to approve such systems if they meet the criteria set forth in the provision and other criteria as established by the Secretary.

The provision also permits the Secretary to take into account previous reductions in medicare rates of increase due to the operation of a state hospital reimbursement control system. The conferees included this provision because of their concern that State programs which control substantially all revenues other than medicare may have already achieved savings for the medicare program through reducing their overall rate of growth in hospital expenditures.

With respect to the authority provided to the Secretary under current law to establish and continue medicare demonstration projects, the Secretary would be prohibited from terminating a project until six months after he notifies the State of his decision to terminate.

11. Elimination of private room subsidy

Senate amendment

The Senate amendment requires the Secretary to publish regulations which would eliminate the subsidy of private hospital rooms. Medicare currently determines its payments to hospitals on the basis of the average costs of all of a hospital's rooms, including its private accommodations, even though medicare generally is intended to cover only the costs of semi-private room accommodations.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment. The provision is intended to direct the Secretary to implement the provisions of current law. The conferees note that elimination of this subsidy does not alter medicare's policy of covering private rooms when medically necessary, and does not alter the options currently available to States to cover such private rooms under medicaid.

12-13. Single reimbursement limits for skilled nursing facilities and home health agencies*Senate amendment*

The Senate amendment requires the Secretary to modify existing regulations which would establish single payment limits for skilled nursing facilities and home health agencies on the basis of the cost experience of free-standing facilities. Separate limits are currently established for such facilities depending on whether they are hospital-based or free-standing facilities.

The amendment would be effective with respect to home health agency cost reporting periods beginning on or after the date of enactment and for skilled nursing facility cost reporting periods beginning on or after October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment. The conferees intend that in establishing the payment limits the Secretary shall make adjustments, as appropriate, based on legitimate cost differences in hospital-based facilities resulting from such factors as a more complex case-mix or the effects of medicare cost allocation requirements.

14. Elimination of duplicate payments for outpatient services*Senate amendment*

The Senate amendment requires the Secretary to issue regulations that would eliminate the duplicate payment of overhead expenses from the recognized charges of a physician who performs services in a hospital's outpatient department. The amendment would be effective with respect to charges for services rendered on or after the date of enactment.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate amendment.

15. Audit and medical claims review

Senate amendment

The Senate amendment requires that the medicare contractor budgets for fiscal years 1983, 1984, and 1985 be supplemented by \$45 million in each year to be spent specifically for provider cost audits and medical review activities.

House committee provision

Similar provision.

Conference agreement

The conference agreement includes the House committee provision.

16. Temporary delay in periodic interim payments

Senate amendment

The Senate amendment modifies the existing periodic interim payment (PIP) procedure for hospitals by providing for a 3 week delay in the flow of PIP payments during September 1983; a similar deferral is authorized during September 1984.

House committee provision

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment.

17. Reimbursement of assistants at surgery

Senate amendment

The Senate amendment prohibits reasonable charge reimbursement for an assistant at surgery in hospitals where an approved training program exists in the specialty, except under the following exceptional circumstances: (1) the service is complex and requires performance by a team of physicians; (2) the patient has multiple conditions which require the presence of, and active care by, a physician of another specialty during an operation, or (3) in the case of exceptional medical circumstances where qualified house staff are not available to assist at surgery. The Senate provision would be effective with respect to services performed on or after October 1, 1982.

House committee provision

Same provision.

Conference agreement

The conference agreement follows the Senate amendment with a modification under which payment may be made on a reasonable charge basis if the services, as determined by the Secretary: (1) are required due to exceptional medical circumstances; (2) are performed by team physicians needed to perform complex medical procedures; (3) constitute concurrent medical care which requires the

presence of, and active care by, a physician of another specialty during surgery; or (4) are required in other circumstances as determined by the Secretary.

18. Judicial review of decision by provider reimbursement review board

Senate amendment

The Senate amendment modifies existing requirements pertaining to judicial review of decisions made by the Provider Reimbursement Review Board (PRRB). Under existing law, judicial actions brought jointly by several providers of services in connection with adverse decisions of the PRRB may be taken only in the U.S. District Court for the District of Columbia. The Senate provision permits Federal judicial review of adverse decisions of the PRRB involving actions brought jointly by several providers of medicare services to be conducted by the U.S. District Court for the district where the "principal party" for the group is located. The provision would be effective on enactment.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

19. Prohibition of payment for ineffective drugs

Senate amendment

The Senate amendment provides for implementation of Section 2103 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) effective October 1, 1982. Section 2103 prohibited the use of Federal funds under medicare part B and under medicaid to pay for certain less than effective drugs. Subsequent legislation has led to delays in the implementation of this provision.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment, with a modification to make the provision effective September 30, 1982.

20. Medicare payments to health maintenance organizations (HMO's)

Senate amendment

The Senate amendment modifies current law requirements for contracting with health maintenance organizations (HMO's) by authorizing prospective reimbursement under risk sharing contracts with competitive medical plans at a rate equal to 95 percent of the average cost of providing services to a medicare beneficiary in the fee-for-service sector (the adjusted average per capita cost—AAPCC).

The Senate amendment includes the current law definition of eligible beneficiaries except that persons medically determined to have end-stage renal disease are excluded. It defines a competitive medical plan as either a Federally-qualified HMO, a State-licensed HMO, or an organization which meets certain service requirements, receives fixed and periodic payments on behalf of enrollees, provides physician services through staff MDs or MDs under contract, assumes financial risk on a prospective basis and meets financial viability standards.

The Senate amendment changes existing enrollment/disenrollment policies by: (a) requiring an annual open enrollment period of at least 30 days; (b) requiring acceptance of beneficiaries in order of application up to capacity with the same exception as under existing law; (c) specifying that a beneficiary may disenroll on a monthly basis with one month's notice; and (d) providing that a plan may not disenroll or refuse to reenroll a beneficiary because of health status or services required.

The Senate amendment would specify that 50 percent of enrollees must be other than medicare or medicaid beneficiaries, however, the Secretary could waive this requirement. In no case could more than 50 percent of enrollees be medicare beneficiaries. The Secretary would be required to establish minimum standards for consumer information to be supplied to eligible beneficiaries.

The Senate amendment would specify that reasonable cost reimbursement be available indefinitely. Under the risk reimbursement contract, the calculation of the Government's contribution would be based on 95 percent of the AAPCC (including certain administrative costs), reflecting such factors as age, sex, institutional status, disability and health status, and place of residence. Plans with at least 1,000 members would be eligible for risk contracts.

The Senate provision would require three new medicare members to enroll in a plan for every current medicare enrollee allowed to convert to the new reimbursement system and that current HMO enrollees turning age 65 would be included in the formula.

The Senate provision would provide that if the adjusted community rate (ACR) for a plan is less than the AAPCC, the plan must spend the difference to provide additional benefits or services; reduction in premiums, deductibles, or copayments; or to provide rebates and dividends to the enrollees. Further, a committee of medicare enrollees must approve the additional benefits.

House committee provision

The House committee provision would authorize a medicare payment option for health maintenance organizations (HMO's). The provision is similar to the Senate amendment except: State licensed HMO's are not included in the definition of an eligible HMO; the length of the annual open enrollment period is to be of "reasonable duration"; services must be accessible to enrollees within the HMO service area; rebates and dividends would not be permitted; two new medicare members must enroll in a plan for every current medicare enrollee allowed to convert under the risk contract; and additional non-optional services would have to be approved by the Secretary.

Conference agreement

The conference agreement follows the Senate amendment with modifications. The agreement authorizes both prospective reimbursement under risk-sharing contracts and cost-based reimbursement under reasonable cost reimbursement contracts for health maintenance organizations (HMO's) and other medical plans. It contains compromise language permitting the Secretary to enter into risk-sharing contracts with eligible organizations which have at least 5,000 members, although this limitation may be waived for plans in non-urbanized areas. The Secretary may enter into reasonable cost reimbursement contracts with eligible organizations which he or she determines do not have the capacity to bear the risk of potential losses under a risk-sharing contract or which so elect or which do not meet the membership size limitation.

The conference agreement defines organizations eligible to enter into contracts under section 1876 as federally qualified HMO's, or HMO's or other plans meeting a generic definition of comprehensive health plans. The Senate amendment regarding State licensed HMO's was not included. The additional requirements with respect to the provision of services to medicare members combine the similar Senate and House committee requirements and include the Senate requirement that the annual open enrollment period must be of at least 30 days duration. As provided in the Senate amendment, an HMO's or plans combined medicare and medicaid enrollment cannot exceed 50 percent except under certain circumstances where a waiver is available.

The conference agreement includes language similar to the Senate amendment describing the actuarial factors to be used in setting the amount of the prospective medicare payment under a risk-sharing contract. In making the adjustment for disability status the Secretary can use his or her discretion as to whether to take into account eligibility for cash payments under the disability insurance program or under SSI.

The conference agreement provides that, as in the House committee provisions, to the extent that the medicare payment exceeds the eligible organization's adjusted community rate under a risk-sharing contract, the organization must use the savings to provide its medicare members with additional health benefits or reduced cost sharing. The Senate amendment permitting rebates and dividends was not included. The Senate amendment requiring that a group of the organization's medicare members must select any additional benefits was also not included, and the House committee language permitting the organization to decide upon the use of the savings was included.

The conference agreement contains the House committee language requiring two new medicare enrollees to enroll for every one current medicare member who converts to the new system under a risk-sharing contract.

The conference agreement retains the identical Senate amendment and House committee language regarding the effective date.

The conferees have agreed upon this delay in implementing this new reimbursement system because of their concern that the adjustments made under the current AAPCC do not adequately re-

flect the relative health care needs (i.e., disability status and other characteristics) of medicare beneficiaries who enroll in the HMO as compared to beneficiaries in the fee-for-service system. The Secretary must develop additional adjustment factors to account for the resulting cost differentials before implementing the program.

Conference agreement

The conference agreement includes the Senate amendment.

22. Hospice care

Senate amendment

The Senate amendment authorizes coverage under medicare part A for hospice care for terminally ill beneficiaries with a life expectancy of six months or less. A medicare beneficiary could elect to receive hospice care in lieu of other medicare benefits except those of the attending physician. Benefits covered include nursing care, therapies, medical social services, homemaker-home health aide services, short-term inpatient care, outpatient drugs for pain relief and respite care. The provision requires that hospices be classified as a separate provider category in the medicare program. Reimbursement would be based on reasonable costs or such other test of reasonableness as the Secretary shall determine, subject to an area adjusted limit or cap set at 40 percent of the average medicare per capita expenditure during the last six months of life for medicare beneficiaries dying of cancer. The provision requires the Secretary to continue the existing Health Care Financing Administration's hospice demonstration projects until the effective date of the hospice benefit. Special exceptions are provided for certain well established hospices.

House committee provision

The House committee provision includes a similar provision.

Conference agreement

The conference agreement follows the Senate amendment with modifications: The benefit period would consist of two periods of 90 days and one period of 30 days; the reference to "speech therapy" would be changed to "speech-language pathology"; copayments would be limited to approximately (i) 5 percent of a hospices cost (as determined by the Secretary) for respite care services, but such coinsurance amount could not exceed the inpatient hospital deductible during a hospice election (as long as the hospice election is not broken by more than 14 days); (ii) in addition, copayments equal to the lesser of, approximately 5 percent of charges or \$5 per prescription, for covered drugs; no reimbursement would be permitted under part B of medicare for an individual's attending physician if the attending physician is employed by the hospice; a hospice program would have to provide directly substantially all of the following core services; nursing care provided by or under the supervision of a registered professional nurse, medical social services under the direction of a physician, physicians services and counseling services; the amendment would be clarified to provide that non-core services, including physical and occupational therapy, speech-

language pathology, home health aide services and homemaker services, medical supplies and inpatient services could be provided "under arrangements" with others; the written plan of care could be reviewed by the attending physician as well as the hospice physician.

The Senate amendment would be clarified to authorize the Secretary to eliminate duplication where any provider requirements under this provision are the same as requirements already met by the provider under other agreements with the Secretary. In addition the Secretary is required to coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type. Hospice would be required to file separate cost reports.

It is the intent of the conferees that hospices provide a basic and coordinated range of services while giving hospices the flexibility to provide, under arrangements, for some services. Hospices would not be required to provide inpatient services directly. However, it is the intention of the conferees that the hospice would be directly responsible for: providing professional supervision over care provided in the inpatient unit; for ensuring that the care provided in the inpatient unit be consistent with the hospice concept of care through the delivery of care or supervision of such care by an interdisciplinary group; and, that the treatment provided be reasonable and necessary for the palliation and management of terminal illness.

Counseling services would be required as a core service under the hospice benefit. The conferees understand that counseling services are an integral part of hospice care however, concern has been expressed regarding the potential cost impact of allowing separate billing for such services. The conferees intention is to permit reimbursement for the salaries of counselors but not to provide reimbursement for services billed as a separate service.

The conferees provided an exception for hospices which commenced operation before January 1, 1975 from; (i) the reimbursement cap; (ii) the limitation on inpatient days; and (iii) the limitation on respite care days. In allowing the above exceptions for these earliest of the Nation's hospices, the conferees intend to give them an opportunity to conform to the prevailing patterns of hospice care and to meet the requirements in the law. The conferees anticipate that no extension of the exemption would be allowed after November 1, 1986, should the basic hospice provision be extended beyond that date.

The provision would be effective for hospice care provided on or after November 1, 1983. The provision would sunset on October 1, 1986, however, an individual who has an election in effect for a period on October 1, 1986, is entitled to hospice care benefits after that date for the remainder of that period and for any subsequent consecutive period to which the individual would have been entitled before such date.

23. Coverage of extended care services without regard to 3-day prior hospitalization requirement

Senate amendment

No provision.

House committee provision

The House committee provision directs the Secretary to provide skilled nursing facility coverage without regard to the 3-day prior hospital stay requirement at such time as, through reimbursement changes or other adjustments, the Secretary determines that this will not lead to an increase in cost and will not alter the acute care nature of the benefit. For persons covered without a prior hospital stay, limitations may be provided on scope or extent of services and on categories of individuals eligible.

Conference agreement

The conference agreement includes the House committee provision.

24. Prohibiting recognition of payments under certain percentage arrangements

Senate amendment

No provision.

House committee provision

Under the House committee provision, no cost which a provider incurs under a contract would be considered reasonable if determined as a percentage (or other proportion) of the provider's reimbursement or claim for reimbursement for services. The provision would not apply to a percentage contract that is reasonable and where such contract is a customary commercial business practice (e.g. commissions paid to salesmen) or provides incentives for the efficient and economical operation of the provider of services.

The provision would generally apply upon enactment. However, for arrangements entered into before enactment, the provision applies one year after enactment, except where provider can unilaterally terminate the arrangement, in which case the provision applies 30 days after the first date that the provider can terminate the arrangement.

Conference agreement

The conference agreement includes the House committee provision with modifications. The prohibition would apply to contracts where the cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement. The provision would be effective upon enactment with certain exceptions as in the House committee provision. The provision would not apply prior to October 1, 1982 to costs incurred under a percentage arrangement where such costs were attributable to the services of a provider-based physician (described in Item 8 of the conference agreement). Beginning October 1, 1982, the provision would not apply to such a provider-based physician where

the limitation on reimbursement for the cost of such a physician's services had been implemented.

25. Interest charges on overpayments and underpayments

Senate amendment

No provision.

House committee provision

The House committee provision requires that once a final determination is made that a provider or supplier has received an overpayment or underpayment from medicare, and payment of the excess or deficit is not made within 30 days of the date of determination, interest charges would be applied to the balance due.

The rate of interest charged would equal the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the 3-month period ending with the month before the month in which the final determination is made. The provision would be effective with respect to final determinations made on or after the date of enactment.

Conference agreement

The conference agreement follows the House committee provision with a modification providing that interest would be determined in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments which are periodically published pursuant to Section 8020.20 of the Treasury Fiscal Requirements Manual.

26. Prohibiting payment for Hill-Burton free care

Senate amendment

No provision.

House committee provision

The House committee provision requires the Secretary to provide, by regulation, that the costs incurred by a hospital or skilled nursing facility in complying with its free care obligation under the Hill-Burton Act would not be considered reasonable costs for purposes of medicare reimbursement. The provision is effective for costs incurred on or after date of enactment.

Conference agreement

The conference agreement includes the House committee provision. The provision is intended to clarify that Hill-Burton free care costs have never been, and are not, allowable for medicare reimbursement purposes. The provision, therefore, applies to all such costs that have been, or will be incurred except those recognized by the final judgment of a U.S. Court of Appeals entered into prior to enactment.

27. Prohibiting payment for anti-unionization activities

Senate provision

No provision.

House committee provision

The House committee provision prohibits medicare reimbursement for costs incurred for activities directly related to influencing employees with respect to unionization. The provision would apply to costs incurred on or after date of enactment.

Conference agreement

The conference agreement includes the House committee provision.

28. Eliminating "lesser of cost or charges" provision*Senate amendment*

No provision.

House committee provision

The House committee provision specifies that the lesser of cost or charges provision would not apply to a class of providers if the Secretary determines and certifies to the Congress that its elimination will not increase medicare payments to that class of provider. It is intent of the conferees that such a determination would take account of both past experience under the provision and possible changes in the cost accounting and charging practices of providers in the absence of the provision.

The provision would be effective on the date the Secretary specifies in his certification to Congress.

Conference agreement

The conference agreement includes the House committee provision. It is the intent of the conferees that the lesser of cost or charges provision be reestablished at such time as the Secretary determines that the non-application of the provision has increased program costs.

29. Extending medicare proficiency examination authority*Senate amendment*

No provision.

House committee provision

The House committee provision extends to September 30, 1983, the period during which the Secretary shall conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal education requirements. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the House committee provision.

30. Prohibiting retroactivity of regulations regarding access to books and records

Senate amendment

No provision.

House committee provision

The House committee provision would prohibit regulations yet to be issued under the authority of section 952 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, from being applied retroactively.

Section 952 of Public Law 95-499 requires the Secretary of HHS or the Comptroller General to have access to the books and records of subcontractors who supply providers with goods and services valued at \$10,000 or more over a 12-month period. The law directs the Secretary to prescribe in regulations the procedures and criteria to be used in obtaining access to such books and records.

The provision would become effective upon enactment.

Conference agreement

The conference agreement includes the House committee provision, with a modification which would prohibit the regulations from being applied retroactively unless such regulations are issued in final form prior to January 1, 1983, preceded by a comment period of no less than 60 days.

31. Health Care Financing Administration/private sector utilization review initiative

Senate amendment

No provision.

House bill

No provision.

Conference agreement

Under the conference agreement, the Secretary of HHS would be required by statute to undertake an initiative to improve medical review by intermediaries and carriers under Title XVIII of the Social Security Act and to encourage similar review efforts and utilization control activities by private insurers and other private entities. The medicare initiatives shall include the development of fiscal targets and evaluation of the performance of intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

It is the intent of the conferees that, where such review activity results in denial of payment to institutional and other providers under medicare, such providers shall be prohibited from collecting any payments from beneficiaries (in excess of those otherwise provided for under current medicare law.)

32. Special part B enrollment without penalty (Merchant Seamen)

Senate amendment

No provision.

House committee provision

The House committee provision establishes a special enrollment period for medicare part B beginning on the first day of the first month beginning at least 20 days following enactment, and ending on December 31, 1982. During that period, otherwise eligible merchant seamen and other individuals would have a one-time opportunity to enroll in part B without incurring the current law penalty of higher premium payments for delayed enrollment.

Conference agreement

The conference agreement includes the House committee provision, modified to provide the special open enrollment period for merchant seamen only.

SUBTITLE B—MEDICAID PROVISIONS

1. Copayments by medicaid recipients

Senate amendment

The Senate amendment permits States to impose nominal copayments on all beneficiaries for all services with certain exceptions. The Senate provision provides for the following limitations on copayments:

(a) Precludes States from imposing such charges with respect to inpatient hospital services and mandatory ambulatory services for categorically needy children under 18 and services related to the pregnancy of categorically needy women, and permits States similarly to exclude medically needy children and pregnant women from copayments.

(b) Precludes States from imposing copayments with respect to all services provided to categorically needy SNF/ICF patients; permits States to exempt medically needy SNF/ICF patients from copayments.

(c) Precludes States from imposing copayments on emergency services for categorically needy persons.

(d) Permits States to exempt all HMO enrollees from copayments.

The provision would be effective on enactment.

House committee provision

The House Committee provision permits States to impose nominal copayments on all beneficiaries for all services with certain exceptions. The provision specifies a \$1 maximum allowable copayment amount for hospital, physician, outpatient, and clinic services for the categorically needy; copayments of up to \$4 would be allowed for non-emergency services in emergency rooms.

The provision also provides for the following limitations on copayments:

(a) Precludes States from imposing charges with respect to all services for categorically needy and medically needy pregnant women and children under 21.

(b) Precludes States from imposing copayments with respect to all services provided to categorically needy SNF/ICF patients.

(c) Precludes States from imposing copayments on emergency services for categorically needy and medically needy persons.

(d) Precludes States from imposing copayments on categorically needy recipients enrolled in an HMO.

(e) Precludes States from imposing copayments on family planning services.

The House provision would be effective October 1, 1982.

Conference agreement

The conference agreement is similar to the Senate provision with modifications. The conference agreement specifies, with one exception, that all copayments must be nominal in amount. The conferees intend that the existing regulations defining "nominal" will continue to serve as the basis for determining whether proposed copayment charges meet the statutory requirements. If the Secretary determines in the future that adjustments to the current regulations are to be made, it is the intention of the conferees that the levels of cash assistance in the States should be considered. The conferees recognize that persons depending on cash assistance have little available income to make copayments, and the standards for nominality should be such that the copayments do not serve as a barrier to receipt of necessary medical services. The conferees intend that the Secretary, in promulgating regulations implementing this provision, adhere to the requirements for notice and opportunity for comment under the Administrative Procedures Act, 5 U.S.C. 553(a)(2), including the issuance of a notice of proposed rule-making. The Secretary may not redelegate the definition of "nominality" to the States.

The "nominal" requirement cannot be waived except for demonstration under tightly limited circumstances, with one exception. The Secretary could waive the requirement limiting copayments to nominal amounts in the case of nonemergency services in emergency rooms where the State has established to the satisfaction of the Secretary that alternative sources of nonemergency outpatient services are actually available and accessible. Where the Secretary is satisfied that such conditions have been met, and a waiver has been granted, the State may impose a charge up to twice the amount defined as nominal by the Secretary in regulations.

The conference agreement precludes States from imposing copayments on children under age 18; States may provide that no copayments would be imposed for children aged 18 to 21. The agreement also precludes States from imposing copayments on services related to pregnancy (including prenatal, delivery, and post partum services). States may at their option provide that no copayments would be imposed for any service provided to pregnant women. These limitations would apply to both categorically needy and medically needy persons.

The conference agreement bars States from imposing copayments on all services provided to inpatients in SNF's and ICF's who are required to spend all their income for medical expenses except for the amount exempted under the State standard for personal needs (which cannot be less than the SSI payment for persons in medical institutions, and which may be more). This prohibition on copayments also extends both to the categorically needy and medically needy population groups.

The conference agreement bars States from imposing copayments on categorically needy HMO enrollees. States may also exempt medically needy HMO enrollees from such charges.

With these exceptions, the conference agreement makes no changes in the comparability requirements of current law.

Additionally, the agreement provides that copayments may not be imposed on family planning services or emergency services for either categorically needy or medically needy individuals.

The conference agreement is designed to allow States to deter unnecessary utilization while not imposing an unreasonable hardship on beneficiaries. The conference agreement therefore includes a provision which specifies that no provider participating under medicaid may deny care or services to an individual because of his or her inability to pay the required cost-sharing charges. This does not excuse the beneficiary from liability for paying such charges.

2. Elimination of Federal matching for medicare part B buy-in

Senate amendment

The Senate amendment eliminates Federal matching for all medicare part B premium payments. Most State medicaid plans currently make the monthly medicare part B premium payment for their dual eligible beneficiaries under a "buy-in" agreement. Federal matching for premium payments is only available for the cash assistance groups.

The provision is effective with respect to premiums due for months after September 1982.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate provision.

3. Modifications in Lien Provision

(A) LIENS

Senate amendment

The Senate amendment allows States to impose liens on the real property, including the home, of institutionalized medicaid recipients who fail to make a showing that they reasonably expect to be discharged from a nursing home or other long-term medical institution and return home.

The Senate amendment specifies that the lien could not be foreclosed (and States could not recover the cost of medical assistance provided) until the recipient voluntarily chooses to sell the proper-

ty, or, until after the recipient's death, and the death of the surviving spouse and/or any children who are under 21, blind or disabled.

House committee provision

The House Committee provision allows States to impose liens on real property, including the home, of institutionalized medicaid recipients who the State establishes are reasonably likely to remain in a nursing home for the remainder of their lives.

The House Committee provision is similar to the Senate provision with respect to allowable foreclosure actions. However, it specifies that the State could also not execute a lien while a recipient's sibling, son, or daughter is lawfully residing in the home and was living in the home for at least one year immediately prior to the recipient's admission to the nursing home. Further, if the home is sold before the lien is executed, the proceeds would be put in trust and used to meet the support needs of the spouse and minor or disabled child.

Conference agreement

The conference agreement follows the Senate amendment with modifications. States are allowed to impose liens on real property, including the home, of institutionalized medicaid beneficiaries who the State determines, after notice and opportunity for a hearing, are reasonably likely to remain in a nursing home for the remainder of their lives. The burden of proof in this determination, which is to be conducted in accordance with procedures established by the State, is on the State. States are not authorized to impose liens on the homes of beneficiaries if the spouse, or blind, disabled or dependent child is residing in the home, or if a beneficiary's sibling is residing in the home who has equity in the home and who has lived there continuously since at least one year prior to the beneficiary's admission to the nursing home.

The agreement further specifies that while a State may impose a lien, it may not foreclose upon the property while a beneficiary's adult son or daughter is residing in the home if he or she (1) has lived in the home continuously for at least two years prior to the beneficiary's admission to the nursing home; and (2) has provided care to the beneficiary that permitted the individual to delay institutionalization; or if a sibling, even though without equity in the home, has lived there continuously since at least one year prior to the beneficiary's institutionalization.

(B) TRANSFER OF ASSETS

Senate amendment

The Senate amendment allows States to deny medicaid eligibility for 24 months and (at State option) for a longer period to persons who dispose of their homes for less than fair market value, within 24 months prior to admission to an institution even though such disposal would not make them ineligible for SSI.

States could either deny eligibility to all such individuals for periods reasonably related to the uncompensated value, or they could deny eligibility in all cases for a minimum of 24 months, with the

option to provide for longer periods of ineligibility in the case of individuals who disposed of homes worth substantial amounts. The provision would not apply in the case of individuals who reasonably expected to be discharged from the medical institution and return home; individuals who demonstrated that they had intended to obtain fair market value or other valuable consideration in exchange for their homes; or individuals who transferred title to their homes to a spouse or a minor or handicapped child. The State could also make an exception in other cases where undue hardship would otherwise result.

House committee provision

The House Committee provision is similar to the Senate amendment. However, the provision applies to transfers for less than fair market value within 24 months prior to application for benefits. In addition, the provision allows States to deny medicaid coverage for a period computed in a manner such that the cost of the services that would otherwise be provided to the individual during this period bears a reasonable relationship to the amount of the uncompensated value of the home. The period of ineligibility would begin with the month in which the home was disposed of.

Conference agreement

The conference agreement follows the Senate amendment with modifications to specify that the period of ineligibility is 24 months from the date of transfer, except that States: (a) are allowed to deny eligibility for a longer period if the uncompensated value of the home is greater than the cost of 24 months of medicaid benefits; and (b) are required to set a shorter time period if the uncompensated value of the home is less than 24 months of medicaid benefits. Under either circumstance, the period of eligibility delay must be related to the uncompensated value of the home, based on the beneficiary's equity, and the cost of medicaid benefits. The provision applies to transfers for less than fair market value occurring up to 24 months prior to application for medicaid benefits.

The conference agreement also amends existing law transfer of assets policy by allowing a State to waive the delay of medicaid eligibility in cases of undue hardship. The conferees also note that the change in SSI policy which exempts burial spaces and certain policies from an individual's resources (see item No. 6 of Subtitle F) has the effect of also exempting such items from an individual's resources for purposes of determining medicaid eligibility in most States.

(C) EFFECTIVE DATE

Senate amendment

The Senate amendment is effective on enactment.

House committee provision

The House Committee provision applies to applications for assistance filed on or after October 1, 1982.

Conference agreement

The conference agreement specifies enactment as the effective date for the lien provisions and specifies that the provision applies with respect to transfers of assets occurring after the date of enactment.

4. Limitation on Federal financial participation in erroneous medical assistance expenditures

Senate amendment

The Senate amendment deletes the Medicaid error rate provisions and penalties incorporated in the 1980 Appropriations Act and substitutes language establishing a 3 percent target error rate for quarters beginning after March 30, 1983. The provision provides that prospective fiscal sanctions are to be applied beginning in the second half of FY83 for States which have error rates exceeding 3 percent. The Secretary is provided discretion in applying the fiscal penalties, in whole or in part, for a State which has made good faith efforts to meet the target. The provision is effective on enactment.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate provision with modifications. Technical errors, i.e., errors which if corrected would not have made a difference in the amount of medical assistance paid, would be excluded from the calculation. The agreement specifies that where errors are made relating to amounts of medical expenses that must be incurred to establish Medicaid eligibility (the "spend-down" requirement), only the smaller of the amount of medical assistance provided or the amount of the spend-down that was miscalculated shall be determined to be an erroneous payment. Further, errors in determination of resources are treated in a similar manner: only the smaller of the amount of medical assistance provided or the amount of miscalculation of the resource which exceeded the allowable resource level will be counted as an erroneous payment.

5. Optional medicaid coverage for individuals who would have qualified for AFDC but for amendments to the earned income disregard and related provisions

Senate amendment

The Senate amendment allows States to continue medicaid coverage for working families who are made ineligible for AFDC as a result of certain changes made by the Omnibus Budget Reconciliation Act of 1981. (Public Law 97-35). These changes, relating to the earned income disregard and work expense deductions, resulted in the loss of AFDC eligibility, and therefore automatic medicaid coverage, for certain individuals. The amendment would be effective for calendar quarters beginning after the date of enactment.

House committee provision

Similar provision.

Conference agreement

The conference agreement does not contain the Senate amendment or the House Committee provision.

6. Medicaid coverage of home care of certain disabled children*Senate amendment*

No provision.

House committee provision

The House committee provision provides States with the option of covering under Medicaid certain disabled children age 18 or under who are living at home. A State could extend such protection to an individual who would be eligible for SSI, and therefore Medicaid, if he was in a medical institution. Further, the State must determine that: (a) the child requires the level of care provided in an institution; (b) it is appropriate to provide such care outside of the institution; and (c) the estimated cost of care at home is no more expensive than the estimated cost of institutional care.

Conference agreement

The conference agreement includes the House committee provision.

7. Technical corrections relating to medicaid*Senate amendment*

The Senate amendment makes technical changes in Public Law 97-35.

House committee provision

The House committee provision includes identical technical changes with one additional provision specifying that the Secretary is not authorized to waive the requirements for State contracting on a risk basis with HMO's and other prepaid entities found in section 1903(m) of the Social Security Act.

Conference agreement

The conference agreement follows the Senate provision with a modification to delete the Secretary's authority to waive the section 1903(m) requirements. However, the conferees recognize that some waivers of section 1903(m) have already been granted. In order to minimize the disruption of arrangements which have already been implemented under these waivers, the conference agreement specifies that the limitation on the Secretary's waiver authority shall not apply where a waiver was granted by the Secretary and the waived arrangements were in effect prior to August 10, 1982. This exemption extends only for the period for which the waiver was initially approved.

It is understanding of the conferees that the types of entities subject to the requirements of section 1903(m) would not include con-

tractual arrangements between the State and an individual physician, or a group of physicians, under which (1) case management is the primary purpose; (2) hospital services are not provided directly by, or under contract for payment to, such physician or physician group; (3) the physician or physician group receives at least 25% of its gross revenues from non-Medicaid and non-Medicare patients (through fee-for-service or other reimbursement methods); (4) the Medicaid revenues that the physician or physician group would otherwise receive from the arrangement will not increase more than 20% as a result of a decrease in the use by beneficiaries under management of hospital and other covered services; and (5) primary care services are available on a 24-hour basis.

The conference agreement makes explicit current law related to coverage of the optional categorically needy, as reflected in current regulations at 42 CFR § 435.210 *et seq.* The conferees do not intend any change in current law through this recodification.

8. Medicaid funding in American Samoa

Senate amendment

No provision.

House bill

No provision.

Conference agreement

The conferees agreed to a provision providing medicaid funding to the territory of American Samoa. Federal matching of 50 percent of expenditures would be authorized, up to a maximum Federal contribution of \$750,000 per year. Due to the unique circumstances in the health system in American Samoa, the Secretary is authorized to waive any provisions of title XIX except the requirements (1) of State matching, (2) of the maximum amount of Federal funds that can be spent, and (3) that expenditures be for health services covered under the title.

9. Nursing home deregulation moratorium

Senate amendment

No provision.

House committee provision

No provision.

Conference agreement

The conferees agreed to a provision which would preclude the Department of Health and Human Services from implementing certain proposed changes regarding survey and certification requirements for nursing homes for 6 months from the date of enactment of this provision. The intent of the conferees in establishing this moratorium is to provide opportunity for the further review, revision or withdrawal of the proposed regulations, published in the Federal Register on May 27, 1982. The conferees anticipate that the Secretary would consult with the Congress, the General Ac-

counting Office, groups representing nursing home residents, state survey and certification agencies and nursing home operators prior to resubmitting the regulations. The conferees do not intend to preclude courts with proper jurisdiction from ordering changes in the current regulations prior to the end of the moratorium.

SUBTITLE C—UTILIZATION AND QUALITY CONTROL PEER REVIEW

1. Establishment of utilization and quality control peer review program

Senate amendment

The Senate amendment repeals the existing Professional Standards Review Organization (PSRO) program and requires the Secretary to enter into contracts for utilization and quality control peer review. The Secretary would also be required to consolidate geographic areas previously established for PSRO's.

The provision requires the Secretary to enter into contracts with peer review organizations for an initial period of 2 years, renewable biennially. The organizations must be composed of, or have available to them, a substantial number of licensed doctors of medicine or osteopathy actually practicing in the area. Priority consideration must be given to physician-sponsored organizations who are representative of the physicians in the area. Payor and provider organizations would be excluded from consideration during the first 12 months that contract applications are considered.

Review organizations, which can be proprietary or nonprofit, may review the professional activities of physicians, other practitioners and institutional and noninstitutional providers in providing services to medicare beneficiaries subject to the provisions of these contracts. The review will focus on (1) the necessity and reasonableness of care, (2) quality of care, and (3) the appropriateness of the setting.

House bill

No provision.

Conference agreement

The conference agreement follows, with modifications, the Senate provision repealing the existing Professional Standards Review Organization (PSRO) program and requiring the Secretary of HHS to enter into performance contracts for utilization and quality control peer review.

The conference agreement follows the Senate amendment requiring the Secretary to consolidate existing PSRO review areas. The conferees intend that the Secretary, in consolidating review areas, shall maximize administrative and review efficiency. The conferees intend that the Secretary will not terminate small PSRO's that are operating effectively and efficiently but will instead permit such PSRO's to contract with the new review organization for that area without duplication of administrative costs.

The conference agreement follows the Senate amendment regarding the conclusiveness of determinations respecting payment. It is the understanding of the conferees that, where such review ac-

tivity results in denial of payment to institutional or other providers under medicare, such providers will be, as under current law, prohibited from collecting any payments from beneficiaries in excess of those otherwise provided for under current medicare law.

The conference agreement follows the Senate amendment requiring 2-year contracts with peer review organizations composed of, or having available, a substantial number of licensed physicians with a modification which would:

(a) prohibit contracts with provider or provider-affiliated organizations (although subcontracts for delegated review purposes with such organizations would be permitted) and

(b) provide that contract termination procedures would not apply to contract nonrenewals.

The conferees intend that review organizations avoid financial conflicts of interest with providers subject to review. The conference agreement prohibits the Secretary from entering into a contract with an entity which is, or is affiliated through management, ownership, or common control with, a health care facility or association of such facilities whose services they would be responsible for reviewing. The conference agreement does not, however, bar a review organization from delegating the review function to a provider by subcontract, if the organization finds that the provider will effectively and efficiently review itself.

The conference agreement follows the Senate provision exempting review organizations from the Freedom of Information Act and establishing disclosure rules for such organizations that apply uniformly to both public and private review activities undertaken by the organizations, with a modification which would:

(a) require the review organization to disclose to the appropriate State agency information identifying a particular practitioner or provider when, in the organization's judgment, there is a reason to believe that a risk to the public health exists, and

(b) require the review organization to disclose information to a State or Federal fraud or abuse agency or an authorized State licensure or certification agency, but only at the request of such agency on a case-by-case basis. This information could include institution or practitioner-specific data.

The conference agreement follows the Senate provision relating to the transition from the existing PSRO program with a modification which would prohibit the Secretary from terminating a PSRO in effect on the earlier of September 30, 1982 or enactment, until such time as the Secretary has entered into a contract with a review organization in that area under this provision.

The conference agreement follows the Senate provision requiring the Secretary to report to the Congress annually with a modification requiring the Secretary to provide information on the efficiency of payment methodologies used by the Secretary in contracting with review organizations.

SUBTITLE D—AID TO FAMILIES WITH DEPENDENT CHILDREN

1. Rounding of eligibility and benefit amounts

Senate amendment

The Senate amendment requires States to round both their AFDC need standard and actual monthly benefit amounts to the next lower whole dollar. The provision is effective October 1, 1982, or later if State conforming legislation is needed.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

2. Effective date of application; proration of first month's benefit

Senate amendment

The Senate amendment prohibits States from making benefits payable for any period prior to the date an application is filed. Any payment for the first month of eligibility would be prorated based on the date of the application. The provision is effective October 1, 1982, or later if State conforming legislation is needed.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

3. Absence from home solely by reason of uniformed service

Senate amendment

Under the Senate amendment, AFDC would no longer be payable to families if the parent is absent solely because of active duty in the uniformed service. The provision is effective October 1, 1982, or later if State conforming legislation is needed.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

4. Sanction for termination or reduction of employment.

Senate amendment

The Senate amendment provides the Secretary of Health and Human Services authority to prescribe sanctions for individuals who are exempt from registration for the work incentive (WIN) program because they are employed 30 or more hours a week, or who live in an area so remote from a WIN program that their participation is precluded if they refuse a bona fide offer of employ-

ment, terminate employment, or reduce their hours of employment, without good cause.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

5. Job search

Senate amendment

The Senate amendment requires State welfare agencies to establish mandatory employment search programs for both applicants and recipients of AFDC. An individual who is required to register for WIN (or who would be required to register except for remoteness from a WIN site) would be required to participate beginning at the time of application. The individual would also be required annually to participate in a program of employment search after his application becomes effective whenever the State prescribes, but not more than a total of 8 weeks in each year. An individual who fails to comply with the employment search requirement, would be subject to sanctions in the same manner as under the WIN program. (The WIN sanctions provide that in the case of the principal earner in an unemployed parent family, the sanction is denial of benefits for the entire family. In other cases, the individual who refuses is removed from the grant and the family's benefit is reduced. The sanction period is 3 months in the case of a first refusal and 6 months in the case of any subsequent refusals.)

House committee provision

The committee provision differs from the Senate amendment as follows:

- (1) It is optional with the States.
- (2) It allows States to limit participation to certain groups or classes of individuals who are required to register for WIN.
- (3) It allows the State to shorten the duration of the sanction period.
- (4) It includes a provision which specifically requires payment to the individual of transportation and other costs necessarily incurred.
- (5) It provides 50 percent Federal matching for costs of transportation and other necessary services.
- (6) It prohibits States from using the job search requirement as a reason for any delay in making a determination of an individual's eligibility or in issuing a payment to an individual who is otherwise eligible.
- (7) It allows an initial 8-week search period, and an additional 8-week period each year (which could add up to 16 weeks in the first year).

Conference agreement

The conference agreement follows the House committee provision, but with the Senate effective date of October 1, 1982.

6. Inclusion and exclusion of specified individuals' needs and income

(A) ELIGIBILITY OF A PARENT

Senate amendment

In determining the AFDC benefit, States are currently permitted to include the needs of a parent or caretaker relative so long as the youngest child is under age 18 (or, at State option, under 19 if the child is in school and is expected to complete his course of study before reaching his 19th birthday). The Senate amendment requires States to include the needs of a parent or caretaker relative, but only until the youngest child reaches age 16. The income and resources of the ineligible parent would be counted in determining the benefit for the child. The State would continue to include the need of a parent of an older eligible child if the parent is unemployable.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

(B) INCLUDE ALL SIBLINGS IN THE AFDC UNIT

Senate amendment

Currently, an AFDC family may choose to exclude a child from the assistance unit if that child has income which would reduce the amount of the family's benefit. The Senate amendment requires States to include all children in the family unit (except disabled children receiving SSI benefits, and certain stepbrothers and stepsisters) in determining the amount of AFDC for which the family is eligible.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

(C) COUNTING INCOME OF GRANDPARENTS

Senate amendment

Currently, the income of parents of a minor child, who is herself the parent of a child, is not counted in determining the eligibility and benefit of the grandchild. The Senate amendment requires States, when the AFDC parent is a minor, to count the income of

the grandparents who are living in the same household as available to the grandchild, after setting aside certain amounts to cover their own needs. The AFDC payment would be made to the grandparent.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

(D) COUNTING INCOME OF UNRELATED INDIVIDUALS

Senate amendment

Under current law, the income of an unrelated adult in an AFDC household may not be presumed to be available to the household, and the welfare agency may count only actual contributions which it knows have been made by the individual to the AFDC family. The Senate amendment requires States to count the income of any person living with the child who is not related to the child or parent or to any other individual living in the household. The income of the unrelated individual would be considered available to the AFDC family, after setting aside certain amounts to cover the needs of the unrelated person and any dependents.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

7. Repeal of emergency assistance program

Senate amendment

The emergency assistance program provides 50 percent matching for emergency assistance (in the form of cash, medical care, or services) to families with children, including both AFDC and non-AFDC families. Assistance may be provided for no more than 30 days in any 12 month period. The program is optional with the States. Under the Senate amendment, this program would be repealed, effective October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

8. Proration of standard amount for shelter and utilities

Senate amendment

AFDC regulations generally prohibit the States from prorating or otherwise reducing the AFDC benefit solely because of the presence in the household of an individual who is not legally responsible to support the family. This general prohibition was modified in Public Law 96-272 to allow States to prorate the shelter and utilities portion of the AFDC benefit in the case of "child only" family units, i.e., when the caretaker is not eligible for assistance.

The Senate amendment allows States to prorate the portion of the AFDC grant for shelter and utilities whenever the assistance unit shares the household with other individuals. The amendment gives States flexibility in determining how the proration provision would be applied. It requires that proration be accomplished "on a reasonable basis," and in a manner and under circumstances prescribed by the State. States could not prorate in the case of a recipient of Supplemental Security Income benefits to whom the one-third reduction applies. (The one-third reduction in the SSI benefit occurs when individuals are determined to be living in the household of another and receiving in-kind income in the form of food and shelter.) The effective date is October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

9. Limitation on Federal financial participation in erroneous assistance expenditures

Senate amendment

Under current law, the "Michel amendment" requires States to reduce their AFDC payment error rate to 4 percent by September 30, 1982. Regulations require the States to achieve one-third progress toward the 4-percent payment error rate (measured from their error rate for the base period April-September 1978) by September 30, 1980, and two-thirds progress by September 30, 1981. The 4-percent goal is the standard for all assessment periods after September 30, 1982. States may be sanctioned by being required to repay the Federal Government the Federal cost of improperly paid benefits, as determined by quality control surveys. The Secretary may waive sanctions where he determines, in certain limited cases, that a State is unable to reach the required reduction in a given year despite a good faith effort.

The amendment continues the 4-percent error rate tolerance level for fiscal year 1983 and reduces it to 3 percent for fiscal year 1984 and years thereafter. Until April 1, 1983, any sanctions would continue to be applied under the existing authority of the Michel amendment. Starting on that date a new sanction authority would be established, under which Federal payments to the States for AFDC matching will be reduced each quarter on a current basis to reflect the Secretary's estimates as to the error rate prevailing in

the State program during that quarter. If the Secretary's estimates are incorrect appropriate adjustments would be made in subsequent grants. The present authority of the Secretary to waive the sanctions in limited cases where he finds that States have failed to meet the target error rates despite a good faith effort to do so would be continued.

House bill

No provision.

Conference agreement

The conference agreement includes the Senate provision which continues the 4-percent error rate tolerance level for fiscal year 1983 and reduces it to 3 percent for 1984 and years thereafter. However, the conference agreement does not include the provisions which would give the Secretary of HHS the authority to reduce Federal matching each quarter on a prospective basis to reflect his estimates as to the error rate estimated in the State program during that quarter.

10. Households headed by minor parents

Senate amendment

The Senate amendment provides that, in order to qualify for AFDC benefits, a minor parent and her child would have to reside in the home of the minor parent's own parent or guardian. This requirement would not apply where: the minor parent was married at the time of (or any time prior to) application for benefits; the minor parent has no parent or legal guardian who is living and whose whereabouts are known; the State agency determines that the health and safety of the minor parent or child would be seriously jeopardized if they lived in the same residence with the parent or legal guardian; or, the minor parent lived apart from the parent or legal guardian for a period of at least one year prior to the birth of the child.

House bill

No provision.

Conference agreement

The Senate recedes.

11. Exclusion from income of certain State payments

Senate amendment

A provision in the 1981 Reconciliation Act (P.L. 97-35) required States to determine AFDC benefits on the basis of the family's income in the preceding month. Under certain circumstances, payment may be determined on the basis of income in the second preceding month. This may be necessary, for example, when the payment date is in the first week of the month and the State needs time to process the monthly report of income which must be submitted by the recipient. In either case, States may wish to supplement the AFDC payment with a non-Federally matched State pay-

ment in certain situations—for example, when a family loses employment and suffers an immediate loss of income. Under present law, however, if the State decides to assist a family during a payment adjustment lag, any supplement which it pays to the family is counted as income for the purpose of computing the following month's AFDC check.

The Senate amendment allows States to compensate for payment adjustment lags by excluding from the calculation of AFDC benefit amounts any payments which are determined to have been paid by the State in recognition of the difference between the current or anticipated needs of the family for a month based upon actual income for the month, and the needs of the family as determined under the retrospective accounting procedure. The effective date is October 1, 1982.

House committee provision

The provision is the same (with technical differences).

Conference agreement

The conference agreement follows the Senate amendment.

12. Extension of time for States to establish a work incentive demonstration program

Senate amendment

The 1981 Reconciliation Act (P.L. 97-35) included a provision authorizing States to operate 3-year demonstration programs as alternatives to the current WIN program. The demonstration is aimed at testing single-agency administration and must be operated under the direction of the State welfare agency. The legislation required States to submit an application to the Secretary of HHS specifying intent to operate a WIN demonstration program. This application had to be submitted within 60 days after enactment.

The Senate amendment allows States a period of two additional years in which to exercise their option to operate a WIN demonstration program. This would give the States until June 30, 1984 to make this decision. The authority which the Secretary now has to waive requirements for participation in WIN would be extended to the demonstration programs. The provision is effective upon enactment.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

13. Exclusion from income

Senate amendment

No provision.

House committee provision

Under current law, income received by an AFDC household is generally counted as income in determining eligibility for and amount of assistance, unless specifically excluded. The Department of Health and Human Services has not in the past required that certain State payments be considered income for purposes of determining AFDC eligibility or amount of benefits. These are payments that are financed wholly from State funds to meet the needs of children receiving AFDC which are not met by the regular payment.

The committee provision allows States to continue to exclude from countable income, both in the month of receipt and in future months, certain special payments made by a State to AFDC households. To qualify for such an exclusion, the payments must have been originally authorized by State statute prior to January 1, 1979; be paid entirely from State funds by the State agency administering the AFDC program; and be provided to meet the needs of AFDC children. The effective date is October 1, 1982.

Conference agreement

The conference agreement follows the House committee provision, effective upon enactment.

14. Technical amendments to social services and foster care

Senate amendment

No provision.

House bill

(1) The 1981 Reconciliation Act (P.L. 97-35) unintentionally repealed the authority for Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands to finance social services from funds received under the cash assistance titles, and provided that these territories are eligible for funds for social services only under the title XX social services block grant.

(2) The formula for allocating funds to the States and territories under the title XX social services block grant program could be interpreted in such a way that a portion of the funds are not available for allocation to any jurisdiction.

(3) There are inconsistencies between titles XI and XX of the Social Security Act as to jurisdictions eligible for title XX funds.

(4) Public Law 97-35 incorrectly referenced child day care instead of foster care standards in the requirements that States have standards for foster family home or child care institutions under their title IV-E foster care program.

The House bill makes the following technical corrections:

(1) Restores the option to Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands to use funds available under the cash assistance titles for social services.

(2) Insures that all the title XX funds under the ceiling are available for allotment to the States and other jurisdictions.

(3) Makes the title XI definition of the term "State," as it pertains to title XX funding, consistent with the list of jurisdictions cited in title XX as eligible for funds under the allotment formula.

(4) Incorporates into the title IV-E foster care law the same standards for foster care as were previously required. (Under prior law these standards were incorporated by reference to the standards in title XX which were in effect prior to Public Law 97-35.) The effective date is October 1, 1981.

Conference agreement

The conference agreement follows the House bill.

SUBTITLE E—CHILD SUPPORT ENFORCEMENT

1. Fee for services to non-AFDC families

Senate amendment

Prior law allowed States to provide child support enforcement services to non-AFDC families without charge or to recover costs of serving such families by charging the custodial parent an application fee of up to \$20, and by retaining a portion of any child support payments which were collected.

An amendment to the 1981 Reconciliation Act replaced this optional provision with a requirement that States impose a fee equal to 10 percent of the support owed, to be charged against the absent parent and added to the amount of the collection.

The Senate amendment repeals the Reconciliation Act amendment and restores the fee provisions of prior law under which States had an option as to whether or not to charge for the costs of non-AFDC child support. It gives States the additional option of allowing them to recover costs either from the absent parent or from the custodial parent.

If a State elects to collect from the custodial parent (by deducting the costs from the amount of child support which is collected) the State must have in effect a procedure under which the court or other entity which determines the amount of the support obligation will be notified of the amount by which any support collection will be reduced to reimburse the costs of collection. The effective date is August 13, 1981.

House bill

The House bill includes the same provision but without the requirement of notification to the court.

Conference agreement

The conference agreement follows the Senate amendment.

2. Allotments from pay for child and spousal support owed by members of the uniformed services on active duty

Senate amendment

The Senate amendment adds a new section to title IV-D of the Social Security Act to require allotments from the pay and allowances of any member of the uniformed service (on active duty) when he fails to make child (or child and spousal) support payments. The requirement would arise when the servicemember failed to make support payments in an amount at least equal to the value of 2 months' worth of support. Provisions of the Consum-

er Credit Protection Act would apply so that the percentage of the member's pay which could be subject to allotment would be limited. The amount of the allotment would be the amount of the support payment, as established under a legally enforceable administrative or judicial order. The provision is effective October 1, 1982.

House committee provision

The same provision is included. In addition, there is a requirement that the servicemember be given an opportunity (within a 30-day limit) to consult a judge advocate or other law specialist.

Conference agreement

The conference agreement includes the provision in both bills, modified to reflect the House committee provision.

3. Reimbursement of State agency in initial month of ineligibility for AFDC

Senate amendment

Under present law, amounts of child support collected which are sufficient to make the family ineligible for AFDC must be paid to the family beginning with the first month of ineligibility.

The Senate amendment requires that amounts collected which are sufficient to make the family ineligible will be paid to the family in months *after* the first month of ineligibility. This would allow the State to reimburse itself for AFDC that would have already been paid for that month, before the support was collected and known to have made the family ineligible. Thus, the family would not receive double payment for the same month, once in the form of AFDC, and once as a result of the child support collection. The provision is effective October 1, 1982.

House committee provision

The same provision is included, effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

4. Reduction in certain Federal payments to States under the child support enforcement program

Senate amendment

No provision.

House committee provision

The provision reduces the Federal matching rate for State administrative costs from 75 percent to 65 percent, and reduces the child support incentive payments from 15 to 12 percent. In addition, there would no longer be matching for the costs of court personnel who perform child support enforcement functions. The provision is effective October 1, 1982.

Conference agreement

Under the conference agreement, Federal matching for State administrative costs would be reduced from 75 percent to 70 percent, effective October 1, 1982. Child support incentive payments would be reduced from 15 to 12 percent, effective October 1, 1983. Federal matching for the costs of court personnel would be repealed, effective October 1, 1983.

5. Technical amendments to child support enforcement provisions in Reconciliation Act

Senate amendment

No provision.

House bill

The House bill makes several technical corrections in the child support enforcement provisions contained in Public Law 97-35, including inaccurate references. The effective date is October 1, 1981.

Conference agreement

The conference agreement includes the technical corrections.

SUBTITLE F—SUPPLEMENTAL SECURITY INCOME

1. Effective date of application; Proration of initial SSI benefit payment

Senate amendment

SSI benefits in the month of application would be prorated from the date of application or the date of eligibility, whichever is later, instead of the requirement in present law whereby benefits begin the first of the month in which the recipient applies and meets the eligibility requirements. This amendment would also apply to the month in which an individual reapplies after a period of ineligibility. The provision is effective October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

2. Rounding of SSI eligibility and benefit amounts

Senate amendment

The amendment provides for rounding SSI monthly benefit and income eligibility amounts to the next lower dollar instead of rounding to the next higher ten cents as provided in present law. Rounding would occur after the cost-of-living adjustment had been made. Cost-of-living adjustments in subsequent years would be based on the unrounded benefit and income eligibility amounts so that the provision would have no cumulative effect from year to year. The provision is effective October 1, 1982.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

3. Coordination of SSI and OASDI cost-of-living adjustments*Senate amendment*

The Senate amendment continues the provisions in present law whereby SSI benefits are determined on a 2 month retrospective basis, but modifies present law to coordinate SSI and OASDI benefit increases. The amendment provides that at the time the cost-of-living adjustment is made, the recipient's SSI benefit is based on the OASDI benefit received in the same month. Also, whenever the Secretary determines that there is reliable information concerning a recipient's income in a given month, the SSI benefit would be based on that information. The Secretary would be required to prescribe by regulation the circumstances in which such information could be used to determine the monthly SSI benefit. The provision is effective October 1, 1982.

House bill

The House bill repeals retrospective accounting and requires that SSI benefits be determined on the basis of the income anticipated by the recipient in the current month (prospectively). Thus, a social security or other benefit increase expected to be received in a month would be taken into account in determining that month's SSI benefit.

Conference agreement

The conference agreement follows the Senate amendment.

4. Phaseout of hold harmless protection*Senate amendment*

The legislation enacting the SSI program included "hold harmless" protection for the States which allowed them to supplement the Federal payment to assure that recipients would receive cash benefits equal to their January 1972 benefit levels, with no cost to the State beyond what was spent for benefits on behalf of aged, blind, and disabled persons in 1972.

Because of Federal benefit increases since that time, all except two States—Hawaii and Wisconsin—have lost their hold harmless status. These two States still receive a Federal contribution to their State supplements because of a special provision added to the law in 1976. Under this provision their hold harmless payments are no longer reduced by Federal benefit increases.

The 1982 Continuing Resolution provided a reduction in hold harmless payments for Wisconsin and Hawaii. The Senate amendment continues phasing out the hold harmless payments. Payments would be reduced to 40 percent of what they would otherwise be in 1983, to 20 percent in 1984, with no "hold harmless" payments

made in 1985 and future years. The provision is effective on enactment.

House committee provision

The House committee provision is the same as the Senate amendment but with technical differences.

Conference agreement

The conference agreement follows the House committee provision.

5. Recovery of SSI overpayments

Senate amendment

The Senate amendment would allow the recovery of SSI overpayments from benefits payable under other programs administered by the Social Security Administration (black lung and OASDI benefits.)

House bill.

No provision.

Conference agreement

The conference agreement does not include the Senate amendment.

6. Exclusion from resources of burial plots and certain funds set aside for burial expenses

Senate amendment

The current SSI statute specifies certain assets which an individual may retain without affecting his eligibility for benefits. Excluded are the home, household goods, personal effects, and an automobile of limited value; and liquid assets up to \$1,500 in the case of an individual, or \$2,250 for a couple.

Also excluded under present law are life insurance policies with cash value, but only if the face value of the policy totals less than \$1,500; and burial insurance, irrevocable burial contracts and term life insurance.

The Senate amendment provides that burial spaces for the individual and his immediate family would be excluded as a resource (subject to such limits as to size or value as the Secretary prescribes).

Burial funds for the individual and spouse would also be excluded if they are specifically set aside for this purpose (subject to limits set by the Secretary). Funds set aside that are used for other purposes would reduce future SSI benefits by a like amount. The provision is effective on enactment.

House committee provision

The House committee provision would also exclude burial spaces as a resource as in the Senate amendment but with technical differences. The House committee provision regarding burial funds is the same as the Senate amendment except that it establishes a

limit on the amount of funds that can be excluded equal to \$1,500 each for the individual and spouse. In addition, funds set aside would reduce on a dollar-for-dollar basis the value of life insurance policies (with cash value) which may be owned by the individual before the cash value is counted. In addition, the \$1,500 limit would be reduced by the total of any amounts held by the individual in an irrevocable burial contract or other arrangement made to meet the burial expenses of the individual and spouse. The provision is effective on the first day of the second month after the month of enactment.

Conference agreement

The conference agreement follows the House committee provision but with the following modification:

The Secretary is authorized to exclude as income and resources increases in the value of amounts set aside for burial expenses because of interest earned, and exclude as income and resources any appreciation in the value of specified pre-paid burial arrangements.

7. Mandatory pass-through under State supplementation provisions

Senate amendment

No provision.

House committee provision

The House committee provision modifies present law related to the requirement that States pass through Federal SSI cost-of-living increases. Under present law, a State may meet this requirement by either (1) maintaining the December 1976 level of State supplementation payment for recipients, or (2) providing no less than the total aggregate amount of State supplementation paid by the State in the previous 12-month period. The House committee provision would allow a State to meet the pass-through requirement if the State did not decrease the State supplementation payment below the level in the previous December instead of the December 1976 level required under present law. The provision would be effective for 12-month periods ending after June 1982.

Conference agreement

The conference agreement follows the House committee provision.

8. Treatment of unnegotiated checks under the supplemental security income program

Senate amendment

No provision.

House bill

Under present law, States are credited with their share (included as State supplementation) of benefit checks remaining unnegotiated for more than 180 days. The House bill clarifies the authority for the Federal Government to credit States for unnegotiated SSI

benefit checks which are "State supplementation only" checks. The provision is effective October 1, 1982.

Conference agreement

The conference agreement follows the House bill.

SUBTITLE G—UNEMPLOYMENT COMPENSATION

1. Rounding of unemployment benefits to next lowest dollar

Under present law, States may determine rounding procedures to apply in the calculation of an individual's weekly unemployment benefit. Regular benefits are financed solely by State trust funds. Extended benefits are financed 50 percent from State trust funds and 50 percent from Federal unemployment insurance trust funds.

Senate amendment

The Federal 50 percent matching share of extended unemployment benefits would not be available on that part of extended unemployment benefit payments which result from a failure on the part of the State to have a benefit structure in which benefits are rounded down to the next lower dollar. This provision is effective for benefits payable on or after October 1, 1983. States in which there is no legislative session prior to that date would, however, be given additional time before the provision would become effective.

House bill

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

2. Use of amounts transferred to State unemployment funds pursuant to the Reed Act

Section 903 of the Social Security Act, commonly referred to as the Reed Act, provides for the transfer of any excess Federal Unemployment Tax Act (FUTA) receipts to the individual State accounts in the unemployment Trust Fund. Each State's share is proportionate to its share of wages subject to FUTA taxes. Excess funds have occurred only three times since the passage of the Reed Act—in 1956, 1957, and 1958. Current unobligated balances in the State Reed Act accounts total \$25 million.

Reed Act funds may be used by the States either to pay unemployment benefits or for administrative purposes. However, under present law, authority to use funds credited in 1956 and 1957 for administrative purposes has expired; and authority to use funds credited in 1958 for administrative purposes will expire on July 1, 1983.

Senate amendment

No provision.

House bill

The House provision extends for 10 years the authority for States to use Reed Act funds for administrative purposes. Also, the provi-

offered that employment. Such retroactive benefits could be provided only for weeks during the between-term or recess period for which the person filed a timely claim for benefits and, except for the denial authority provided under this section, would have been eligible to receive benefits.

Conference agreement

The conference agreement follows the House committee provision.

8. Short-time compensation

Under current law, all States provide partial unemployment benefits for claimants who work less than regular full-time hours (as defined by State law). However, most State unemployment insurance laws do not allow partial benefits in a way that encourages "worksharing" and short-time compensation (partial, prorated unemployment benefits to workers whose work-week is reduced in lieu of total layoff of some of a firm's employees). This is because partial benefits under present law generally end when a worker earns slightly more than one-half of full-time wages.

Senate amendment

No provision.

House committee provision

The House committee provision directs the Department of Labor (DOL), upon enactment, to develop model legislation that can be used by States wishing to establish short-time compensation (or "worksharing") programs. DOL is directed to evaluate the operation and impact of any such programs implemented by the States and report its findings to Congress no later than October 1, 1985.

Conference agreement

The conference agreement follows the House committee provision.

TABLE 1.—RECONCILIATION INSTRUCTION

[In millions of dollars]

	Fiscal Year—			Total
	1983	1984	1985	
Senate Finance.....	4,429	5,564	5,976	15,969
Ways and Means.....	3,755	4,827	5,168	13,750
Medicare ¹	3,162	4,122	4,240	11,524
Medicaid ¹	674	737	808	2,219
Public Assistance ¹	593	705	928	2,226

¹ The committees are reconciled only to the total outlay savings. The figures shown for each program represent assumptions used in arriving at the total reconciliation instructions, and are not binding.

TABLE 2.—CONFERENCE AGREEMENT ¹ (PRELIMINARY ESTIMATES)

[In millions of dollars]

	Fiscal Year—			Total
	1983	1984	1985	
Total savings.....	3,695	5,896	7,865	17,456
Medicare.....	2,879	4,430	5,998	13,307
Medicaid.....	275	364	502	1,141
Aid to families with dependent children (AFDC).....	85	95	163	343
Child support enforcement (CSE).....	92	141	151	384
Supplemental security income (SSI).....	116	126	144	386
Unemployment compensation (UC).....	-81	49	49	17
Debt management.....	329	691	858	1,878

¹ This table does not reflect the additional food stamp outlays of \$184 million, and additional medicaid outlays of \$111 million resulting from two medicare provisions over the three-year period. Thus the total net outlays savings are \$17,161 million. The table reflects the savings to each of the programs identified. The minus sign (—) for 1983 in unemployment compensation represents additional outlays.

TABLE 3.—BUDGET IMPACT OF EACH PROVISION WITHIN THE CONFERENCE AGREEMENT

[— means increase in outlays; figures in millions]

	Fiscal year—			Total
	1983	1984	1985	
MEDICARE				
2. Medicare secondary for older workers.....	\$350	\$530	\$600	\$1,480
4. 80 percent radiologist/pathologist (medicaid cost of \$50 million).....	160	210	250	620
7. Elimination of nursing differential.....	95	110	125	330
8. Hospital-based physicians.....	63	73	84	220
9. Part B premium as a constant percentage of costs (medicaid cost of \$61 million) ..	45	240	480	765
10. Compromise—hospital reimbursement (medicaid savings of \$280 million)	480	1,770	3,770	6,020
11. Elimination of private room subsidy.....	54	75	80	209
12–13. Single reimbursement limit for skilled nursing facilities and home health agencies	18	46	46	110
14. Elimination of duplicate payments for outpatient services.....	160	225	270	655
15. Audit and medical claims review.....	130	300	300	730
16. Temporary delay in periodic interim payments	750	100	—870	—20
17. Reimbursement of assistants at surgery.....	55	130	150	335
19. Prohibition of payments for ineffective drugs.....	0	0	0	0
20. Medicare payments to HMO's.....	0	0	0	0
21. Technical corrections	0	0	0	0
22. Hospice care.....	—3	—1	17	13
23. Coverage of extended care services.....	0	0	0	0
24. Percentage arrangements (not for hospital-based physicians)	15	17	20	52
25. Interest on overpayments	25	25	20	70
26. Prohibit payment for Hill-Burton care.....	15	17	20	52
27. Prohibiting payment for antiunionization activities	0	0	0	0
28. Lesser of cost or charges	\$0	\$0	\$0	\$0
29. Extend medicare proficiency exam.....	0	0	0	0
30. Access to books and records.....	0	0	0	0
31. Private sector utilization review	330	385	440	1,155
32. Part B enrollment.....	(^a)	(^a)	(^a)	(^a)
Subtitle C—Utilization and quality control peer review	15	15	20	50
HI tax for Federal employees (outlay savings)	122	163	176	461
Total medicare provisions	2,879	4,430	5,998	13,307

TABLE 3.—BUDGET IMPACT OF EACH PROVISION WITHIN THE CONFERENCE AGREEMENT—Continued

[— means increase in outlays; figures in millions]

	Fiscal year—			Total
	1983	1984	1985	
8. American Samoa.....	-1	-1	-1	-3
9. Nursing home moratorium.....	0	0	0	0
Hospital reimbursement.....	20	80	180	280
AFDC impact on medicaid.....	16	20	25	61
Offset to last year's penalty.....	0	-30	-30	-60
Total medicaid provisions.....	275	354	502	1,141
Impact on medicaid of:				
80 percent radiologist/pathologist ¹	-15	-15	-20	-50
Part B premium ¹	-4	-19	-38	-61
AFDC				
1. Round AFDC benefits.....	9	10	10	29
2. Prorate AFDC benefits.....	13	14	14	41
3. Military service/AFDC.....	15	17	17	49
5. Optional job search.....	5	10	15	30
8. Prorate shelter and utilities.....	43	44	45	132
9. Error rate sanctions.....	0	0	62	62
11. Exclusion from AFDC income of certain state payments.....	0	0	0	0
12. Extend WIN demonstration.....	0	0	0	0
13. Exclude State payments to children.....	0	0	0	0
14. Technical amendments.....	0	0	0	0
Total AFDC provisions.....	85	95	163	343
Food stamp impact of AFDC provisions ²	-39	-44	-46	-129
CSE				
1. Non-AFDC fees.....	12	16	11	39
2. Military allotments.....	7	9	10	26
3. Initial month of ineligibility.....	3	4	4	11
4. Reduce Federal CSE incentive funds and administrative costs.....	70	112	126	308
5. Technical amendments.....	0	0	0	0
Total CSE provisions.....	92	141	151	384
SSI				
1. Prorate SSI benefits.....	26	28	32	86
2. Round SSI benefits.....	20	25	30	75
3. SSI accounting period.....	45	41	43	129
4. Phase out hold harmless.....	30	37	45	112
6. Exclude burial plots and contracts.....	-5	-5	-5	-15
7. Mandatory passthrough under SSI.....	0	0	0	0
8. Unnegotiated SSI checks.....	0	0	-1	-1
Total SSI provisions.....	116	126	144	386
Food stamp impact of SSI provisions ²	-17	-18	-20	-55
Footnotes at end of table.				
UC				
1. Rounding UC benefits.....	0	10	19	29
2. Extend Reed Act.....	0	0	0	0
7. Treatment of school employees.....	7	8	9	24
8. Short time compensation.....	-1	-1	0	-2
Deferral of interest payment on UC loans.....	-87	32	21	-34
Total UC provisions.....	-81	49	49	17

TABLE 3.—BUDGET IMPACT OF EACH PROVISION WITHIN THE CONFERENCE AGREEMENT—Continued

[— means increase in outlays; figures in millions]

	Fiscal year—			Total
	1983	1984	1985	
DEBT MANAGEMENT				
1. Savings bonds	329	691	858	1,878

¹ Increased medicaid outlays due to changes in medicare are scored against total savings for the House, but not the Senate.² Increased food stamp outlays are scored against total savings for the House, but not the Senate.³ Negligible cost.

Note: The estimates for each provision of outlay savings within each program (e.g. Medicare) reflect the savings to that program and not necessarily the total budget impact. If a provision has an impact upon two programs, it is listed twice.

In addition, there is a loss in revenue from item 2 under Medicare (Medicare secondary for older workers) of \$85,130 million and 150 million for fiscal years 1983 to 1985 respectively.

TABLE 4.—Budget Impact of the Provisions to Lower Unemployment Compensation Tax Thresholds and to Provide Federal Supplemental Benefits

(— indicates an expenditure reduction or revenue increase; + indicates an expenditure increase; figures in millions)

	Fiscal year—				Total
	1982	1983	1984	1985	
Lower unemployment compensation tax thresholds (additional revenues)	0	-763	-734	-611	-2,108
Federal supplemental benefits (additional outlays)	175	1,919	0	0	2,094
Administrative cost (additional outlays)	0	20	0	0	20
Impact on food stamps and AFDC (reduced outlays)	0	-209	0	0	-209
Total impact on budget deficit ¹	+175	+967	-734	-611	-203

¹ + means an increase in the deficit; — means a decrease in the deficit.

F. Employment Tax Provisions

1. Independent Contractors

a. Alternative standards for determining classification of workers for employment tax purposes and extension of certain interim provisions

Present law

In general

Common law (i.e., nonstatutory) rules generally apply in determining whether particular workers are treated as employees or as independent contractors (self-employed persons) for Federal employment tax purposes. However, certain individuals are classified by the tax statute as employees for FICA (social security) tax purposes. These statutory FICA employees are certain agent-drivers or commission-drivers, full-time life insurance sales persons, home workers performing services on goods or materials, and full-time traveling or city sales persons.

Interim provisions relating to classification controversies

Section 530 of the Revenue Act of 1978 provided that taxpayers who had a reasonable basis for not treating workers as employees in the past could continue such treatment without incurring employment tax liabilities. This relief was available only if the taxpayer filed all Federal tax returns (including information returns) that are required to be filed with respect to workers whose status is at issue on a basis consistent with the taxpayer's treatment of the workers as independent contractors. Also, the 1978 Act prohibited the Treasury Department from issuing any regulation or revenue ruling that classifies individuals for purposes of employment taxes under interpretations of the common law.

The interim provisions of Section 530 of the Revenue Act of 1978 were extended, by subsequent legislation, through June 30, 1982.

Senate amendment

In general

The satisfaction of a safe-harbor test results in classification of a worker as an independent contractor for Federal employment tax purposes other than under the Railroad Retirement Tax Act. (A statutory FICA tax employee could be classified under the safe-harbor for income tax purposes.) The safe-harbor requirements, generally applicable to post-1982 services, relate to (1) control of hours worked, (2) place of business, (3) investment or income fluctuation, (4) written contract and notice of tax responsibilities, and (5) the filing of required returns. A special rule applies with respect to certain home-health care workers.

Interim provisions relating to classification controversies

The interim provisions (Section 530 of the Revenue Act of 1978) are extended through December 31, 1982.

Conference agreement

Statutory nonemployees.—The conference agreement does not include any safe-harbor test (or any special rule with respect to home-health care workers). The conference agreement establishes two categories of statutory nonemployees. Under this provision, sales persons who are licensed real estate agents, and individuals who are direct sellers, are treated for Federal income and employment tax purposes as self-employed persons where substantially all the remuneration paid for their services as real estate agents or direct sellers is directly related to sales or other output and where such services are performed pursuant to a written contract providing that they will not be treated as employees for Federal tax purposes. In defining direct sellers, the bill's reference to individuals engaged in the trade or business of selling or soliciting the sale of consumer products includes the activities of individuals who attempt to increase direct sales activities of their direct sellers and who realize remuneration dependent on the productivity of those direct sellers. These activities include providing motivation or encouragement, imparting skills, knowledge, or experience, or recruiting activities. Also, in defining qualified real estate agents, the bill's reference to sales persons who are licensed real estate agents includes the appraisal activities of licensed real estate agents in connection with real estate sales activities if such individuals realize remuneration dependent on sales or other output. This provision applies to services performed after 1982.

Interim provisions.—The conference agreement indefinitely extends the interim provisions (section 530 of the Revenue Act of 1978) from July 1, 1982, until such time as the Congress enacts legislation as to the classification of workers as independent contractors or employees. This provision does not prohibit implementation (e.g., through issuance of regulations or rulings) of the provision in the conference agreement relating to statutory nonemployees.

b. Reduction of certain employment tax liabilities where workers are reclassified as employees

Present law

If a worker reclassification occurs, the employer generally is responsible for all employment tax liabilities (income tax withholding, both the employer's and the employee's share of FICA taxes, and FUTA taxes) with respect to the reclassified workers. Federal income tax withholding assessments may be adjusted if the reclassified worker pays (or has paid) the proper amount of income tax. A FICA-SECA offset is authorized only if the reclassified worker is prevented from filing for a refund of the SECA tax paid in error.

House bill

No provision.

3. Extension of Social Security hospital insurance taxes and Medicare coverage to Federal employees

Present law

Federal employees generally are not subject to social security hospital insurance taxes nor does their employment qualify them for Medicare coverage.

House bill

No provision.

Senate amendment

Federal employment would become subject to the hospital insurance portion of the FICA tax, effective January 1, 1983, and the newly covered Federal employment would be used in determining eligibility for protection under medicare part A (hospital insurance). A transitional provision would provide credit for additional hospital insurance quarters of coverage for certain Federal employees who have attained age 57 by 1983, and who otherwise would not qualify for medicare protection even though they have made hospital insurance tax contributions based on their Federal employment.

Conference agreement

The conference agreement follows the Senate amendment, with several clarifying and other changes, as follows: All Federal employment currently excluded from FICA taxes would be covered, except for certain services performed by penal inmates, medical interns and student nurses, and temporary emergency employment; hospital insurance quarters of coverage would be earned and credited in the same way as for other covered employment (i.e., specified amounts of covered earnings in a year would result in specified numbers of quarters of coverage); and the transitional provision, which would apply to Federal employees who perform service during and before January 1983, would give such employees credit toward medicare eligibility (up to the minimum amount required) for past Federal employment. Employees of States and localities, including the District of Columbia, would continue to be exempt from FICA taxes.

The conference agreement permits individuals who have worked for the Federal Government to obtain medicare benefits if they file and meet the insured status and other disability eligibility requirements of the social security disability cash benefits program, even though no such cash benefits would otherwise be payable. The medicare application would be treated as an application for disability benefits (for purposes of determining eligibility to medicare).

The Secretary of Health and Human Services and the Director of the Office of Personnel Management are required fully to inform Federal employees (particularly those who might be or become eligible for medicare benefits because of a disability) of the terms and conditions of medicare eligibility.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

AUGUST 18 (legislative day, AUGUST 17), 1982.—Ordered to be printed

Mr. DOLE, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4961]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4961) to make miscellaneous changes in the tax laws, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

Senate Conference Report 97-530 is identical to House
Conference Report 97-760.

Finder's Aid
P.L. 97-300 (96 Stat. 1322) Approved October 13, 1982
"Job Training Partnership Act"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-537</u>	<u>S.Rep. 97-469</u>	<u>H.C.Rep. 97-889</u>
AFDC--Income Disregard (Technical Amendment)	402(a)(8)(A) (iii)	503(a)(1)	1398	--	--	--
AFDC--Income Disregard (Technical Amendment)	402(a)(8)(A) (iv)	503(a)(2)	1398	--	--	--
AFDC--Income Disregard-- Job Training	402(a)(8)(A)(v) New	503(a)(3)	1398	--	--	104
AFDC--Income Disregard (Technical Amendment)	402(a)(18)	503(b)	1398	--	--	--
AFDC--Job Search Program	432(b)(1)(A)	502(c)(1)	1398	--	31	130, 139
AFDC--Job Training Partnership Services	432(d)	502(a)	1397	57	--	105
AFDC--Private Industry Councils	432(f)(1)	502(b)(1)(A)	1397	6, 35, 42, 57, 63	--	101, 139
AFDC--Private Industry Councils (Technical Amendment)	432(f)(2) Stricken	502(b)(1)(B)	1398	63	--	--
AFDC--Private Industry Councils (Technical Amendment)	432(f)(3) Redesignated as (f)(2)	502(b)(1)(B)	1398	63	--	--
AFDC--Private Industry Councils (Technical Amendment)	432(f)(2)	502(b)(1)(C)	1398	63	--	--
AFDC--Testing and Counseling Priorities-- Unemployed Parents	433(a)	502(c)(2)	1398	--	--	--
AFDC--Private Industry Council (Technical Amendment)	433(b)(2)	502(b)(2)	1398	65	--	--
AFDC--Public and Private Coordination	433(i) New	502(c)(3)	1398	57, 65, 69	--	139

JOB TRAINING PARTNERSHIP ACT

Public Law 97-300
97th Congress

An Act

Oct. 13, 1982

[S. 2036]

Job Training
Partnership Act.

To provide for a job training program and for other purposes.

*Be it enacted by the Senate and House of Representatives of the
United States of America in Congress assembled,*

SHORT TITLE; TABLE OF CONTENTS

29 USC 1501
note.

SECTION 1. This Act may be cited as the "Job Training Partner-
ship Act".

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- Sec. 307. Limitations.
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TITLE IV—FEDERALLY ADMINISTERED PROGRAMS**PART A—EMPLOYMENT AND TRAINING PROGRAMS FOR NATIVE AMERICANS AND MIGRANT AND SEASONAL FARMWORKERS**

- Sec. 401. Native American programs.
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- Sec. 423. Individuals eligible for the Job Corps.
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Sec. 501. Amendments to the Wagner-Peyser Act.

Sec. 502. Amendments to part C of title IV of the Social Security Act.

Sec. 503. Earnings disregard.

Sec. 504. Enforcement of Military Selective Service Act.

STATEMENT OF PURPOSE

29 USC 1501.

SEC. 2. It is the purpose of this Act to establish programs to prepare youth and unskilled adults for entry into the labor force and to afford job training to those economically disadvantaged individuals and other individuals facing serious barriers to employment, who are in special need of such training to obtain productive employment.

AUTHORIZATION OF APPROPRIATIONS

29 USC 1502.
Post, pp. 1358,
1368.

SEC. 3. (a)(1) There are authorized to be appropriated to carry out part A of title II and title IV (other than part B of such title) such sums as may be necessary for fiscal year 1983 and for each succeeding fiscal year.

(2) From the amount appropriated pursuant to paragraph (1) for any fiscal year, an amount equal to not more than 7 percent of the total amount appropriated pursuant to this section shall be available to carry out parts A, C, D, E, F, and G of title IV.

(3) Of the amount so reserved under paragraph (2)—

(A) 5 percent shall be available for part C of title IV, and

(B) \$2,000,000 shall be available for part F of title IV.

(b) There are authorized to be appropriated to carry out part B of title II such sums as may be necessary for fiscal year 1983 and for each succeeding fiscal year.

(c) There are authorized to be appropriated to carry out title III such sums as may be necessary for fiscal year 1983 and for each succeeding fiscal year.

(d) There are authorized to be appropriated \$618,000,000 for fiscal year 1983, and such sums as may be necessary for each succeeding fiscal year, to carry out part B of title IV of this Act.

(e) The authorizations of appropriations contained in this section are subject to the program year provisions of section 161.

Post, pp. 1368,
1380, 1381, 1383,
1387, 1390.

Post, p. 1364.

Post, p. 1364.

Post, p. 1347.

"(3) In conducting any investigation under this Act, the Secretary or the Comptroller General of the United States may not request new compilation of information not readily available to such State.

"(c) Each State receiving funds under this Act shall—

"(1) make such reports concerning its operations and expenditures in such form and containing such information as shall be prescribed by the Secretary, and

"(2) establish and maintain a management information system in accordance with guidelines established by the Secretary designed to facilitate the compilation and analysis of programmatic and financial data necessary for reporting, monitoring, and evaluating purposes."

(g) Section 11(a) of such Act is amended by adding at the end thereof the following new sentence: "Nothing in this section shall be construed to prohibit the Governor from carrying out functions of such State advisory council through the State job training coordinating council in accordance with section 122(c) of the Job Training Partnership Act."

Restrictions.
29 USC 49j.

Ante, p. 1339.

(h) Such Act is amended by adding at the end thereof the following new sections:

"SEC. 13. (a) The Secretary is authorized to establish performance standards for activities under this Act which shall take into account the differences in priorities reflected in State plans.

Performance
standards.
29 USC 49l

"(b) Nothing in this Act shall be construed to prohibit the referral of any applicant to private agencies as long as the applicant is not charged a fee.

Restrictions.

"SEC. 14. There are authorized to be appropriated such sums as may be necessary to enable the Secretary to provide funds through reimburseable agreements with the States to operate statistical programs which are essential for development of estimates of the gross national product and other national statistical series, including those related to employment and unemployment.

Appropriation
authorization.
29 USC 49l-1.

"SEC. 15. This Act may be cited as the 'Wagner-Peyser Act'."

29 USC 49 note

AMENDMENTS TO PART C OF TITLE IV OF THE SOCIAL SECURITY ACT

SEC. 502. (a) Section 432(d) of the Social Security Act is amended to read as follows:

42 USC 632.

"(d) In providing the training and employment services and opportunities required by this part, the Secretary of Labor shall, to the maximum extent feasible, assure that such services and opportunities are provided by using all authority available under this or any other Act. In order to assure that the services and opportunities so required are provided, the Secretary of Labor (1) shall assure, when appropriate, that registrants under this part are referred for training and employment services under the Job Training Partnership Act, and (2) may use the funds appropriated under this part to provide programs required by this part through such other Acts to the same extent and under the same conditions (except as regards the Federal matching percentage) as if appropriated under such other Act and, in making use of the programs of other Federal, State, or local agencies (public or private), the Secretary of Labor may reimburse such agencies for services rendered to individuals under this part to the extent that such services and opportunities are not otherwise available on a nonreimbursable basis."

Ante, p. 1322.

(b)(1) Section 432(f) of such Act is amended—

42 USC 632.

(A) by amending paragraph (1) to read as follows:

Ante, p. 1322.

"(f)(1) The Secretary of Labor shall utilize the services of each private industry council (as established under the Job Training Partnership Act) to identify and provide advice on the types of jobs available or likely to become available in the service delivery area of such council.";

(B) by striking out paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) by striking out "Labor Market Advisory Council" in such paragraph and inserting in lieu thereof "private industry council".

42 USC 633.

(2) Section 433(b)(2) of such Act is amended by striking out "Labor Market Advisory Council (established pursuant to section 432(f))" and inserting in lieu thereof "private industry council under the Job Training Partnership Act".

42 USC 632.

(c)(1) Section 432(b)(1)(A) of such Act is amended by inserting before the comma at the end thereof the following: ", which may include intensive job search services, including participation in group job search activities".

42 USC 633.

(2) Section 433(a) of such Act is amended by striking out "unemployed fathers" and inserting in lieu thereof "unemployed parents who are the principal earners (as defined in section 407)".

(3) Section 433 of such Act is amended by adding at the end thereof the following new subsection:

"(i) In planning for activities under this section, the chief executive officer of each State shall make every effort to coordinate such activities with activities provided by the appropriate private industry council and chief elected official or officials under the Job Training Partnership Act."

EARNINGS DISREGARD

95 Stat. 843.

42 USC 602.

SEC. 503. (a) Section 402(a)(8)(A) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (iii);

(2) in clause (iv), by striking out "already disregarded under the preceding provisions of this paragraph" and inserting in lieu thereof "disregarded under any other clause of this subparagraph"; and

(3) by adding at the end thereof the following new clause;

"(v) may disregard the income of any dependent child applying for or receiving aid to families with dependent children which is derived from a program carried out under the Job Training Partnership Act (as originally enacted), but only in such amounts, and for such period of time (not to exceed six months with respect to earned income) as the Secretary may provide in regulations; and".

95 Stat. 845.

42 USC 602.

(b) Section 402(a)(18) of such Act is amended by inserting ", other than paragraph (8)(A)(v)" after "without application of paragraph (8)".

ENFORCEMENT OF MILITARY SELECTIVE SERVICE ACT

SEC. 504. The Secretary shall insure that each individual participating in any program established under this Act, or receiving any assistance or benefit under this Act, has not violated section 3 of the Military Selective Service Act (50 U.S.C. App. 453) by not presenting and submitting to registration as required pursuant to such section. The Director of the Selective Service System shall cooperate with the Secretary in carrying out this section. 29 USC 1504.

Approved October 13, 1982.

LEGISLATIVE HISTORY—S. 2036 (H.R. 5320)

HOUSE REPORTS: No. 97-537 accompanying H.R. 5320 (Comm. on Education and Labor), No. 97-889 (Comm. of Conference).

SENATE REPORT No. 97-469 (Comm. on Labor and Human Resources).

CONGRESSIONAL RECORD, Vol. 128 (1982):

July 1, considered and passed Senate.

Aug. 4, H.R. 5320 considered and passed Senate; S. 2036, amended, passed in lieu.

Sept. 30, Senate agreed to conference report.

Oct. 1, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 18, No. 41 (1982):

Oct. 13, Presidential statement.

JOB TRAINING PARTNERSHIP ACT

MAY 17, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PERKINS, from the Committee on Education and Labor,
submitted the following

R E P O R T

together with

SUPPLEMENTAL, INDIVIDUAL, SEPARATE AND ADDITIONAL VIEWS

[To accompany H.R. 5320]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 5320) to establish a community public-private training and employment assistance system and to provide employment and training services, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

BACKGROUND

In a time characterized by the highest unemployment since before World War II, no task is more important than to find meaningful employment for all who want to work. In this regard, the Committee on Education and Labor is proposing to enact an improved and more effective comprehensive job training program. This new proposed legislation, which would replace the expiring Comprehensive Employment and Training Act (CETA) program, builds on the existing local government structure for delivering job training and gives a business-dominated Private Industry Council (PIC) equal voice with local elected officials in determining how Federal job training funds are to be spent. It is the Committee's belief that it is imperative to build on the expertise and experience developed through this program over the past decade, but it is also necessary to incorporate new policy

tions in force. Eligible participants for training or retraining include unemployed workers with limited opportunities for employment or reemployment in the same or similar occupation.

Authorized activities

Employment and training services including job search assistance, training, retraining, counseling, labor-management programs and relocation assistance are authorized.

TITLE IV—NATIONAL EMPLOYMENT AND TRAINING PROGRAMS

Programs for migrants and Native Americans are maintained at the national level. Set-asides equal to 27 percent of the funds available for Title II are reserved for services to Native Americans and 2.8 percent are reserved for services to migrant and seasonal farm-workers.

The Job Corps is retained as a separate national program for economically disadvantaged young men and women aged 16 to 25.

Multistate programs increasing coordination with other employment related programs, reducing critical skill shortages and targeting employment and training assistance to persons facing particular disadvantages in the labor market including special programs for veterans to be administered through the Assistant Secretary for Veterans Employment are authorized.

Research, demonstration, and pilot projects, and technical assistance are authorized and a national clearinghouse to disseminate materials and information on exemplary programs is established.

Federal-state cooperative labor market information programs are authorized. The Secretary is required to collect data on plant closures.

The National Commission for Employment Policy is reconstituted as an independent non-governmental Commission to advise the President and the Congress on national employment and training issues.

TITLE V—AMENDMENTS TO OTHER STATUTES

Employment service (Wagner-Peyser Act)

The Wagner-Peyser Act is amended to require the employment service and local prime sponsors to plan jointly for use of funds under Wagner-Peyser. Non-labor exchange duties are eliminated from the Employment Service's functions where not reimbursed.

Funds are allocated on a needs-based formula, with a hold harmless of 90 percent of the prior year's funding. Ten percent of the funds are reserved for the Governor to provide performance incentives, services for groups with special needs, and exemplary models.

Work Incentive Program (WIN)

Title IV-C of the Social Security Act [WIN] is amended to require job search assistance for WIN registrants, require joint planning with the prime sponsors under the Job Training Partnership Act, and utilize the Private Industry Council [PIC] instead of the Labor Market Advisory Council, now authorized under WIN.

COMMITTEE ACTION

Oversight activity

In anticipation of various legislative proposals to replace the expiring Comprehensive Employment and Training Act, the Subcommittee on Employment Opportunities conducted informal seminars and public hearings, and participated in site visits, meetings and conferences on employment and training issues in Washington, D.C. and across the country.

During the first session of the 97th Congress, the Subcommittee initiated a series of informal CETA reauthorization seminars in Washington, D.C., bringing together various groups directly involved with the CETA program. Representatives from the business sector met with the Subcommittee during the July 30, 1981 seminar to share their concerns about training for private sector jobs. On August 3, a similar seminar was conducted with representatives from various prime sponsors across the country. Seminars were conducted on August 10 with representatives of Private Industry Councils and on September 16 with representatives of labor and community-based organizations which focused on their respective roles in the design and delivery of employment and training services under the existing CETA law. These forums were invaluable to the Subcommittee in exploring policy alternatives and soliciting specific recommendations for the development and consideration of an employment and training bill.

The Subcommittee on Employment Opportunities conducted a hearing on full employment in Los Angeles, California on August 13, 1981, which, among other things, explored the potential for expanding employment opportunities for unemployed and under-employed workers. On October 27-28, 1981, the Subcommittee on Employment Opportunities held joint hearings with the Subcommittee on Crime of the House Judiciary Committee on the relationship between unemployment and crime. Numerous witnesses emphasized the importance of the Federal Government's role in continuing to fund programs with a proven record of effectiveness in combatting these interrelated problems—programs such as the Job Corps, supported work programs aimed at ex-convicts and AFDC recipients, and the Summer Youth Employment Program.

The Subcommittee began its oversight hearings on the reauthorization of the Comprehensive Employment and Training Act in Brattleboro, Vermont on November 2, 1981. Approximately 30 witnesses representing the private sector, prime sponsors, economic development agencies, consolidated programs, vocational education agencies, youth groups, and community-based organizations testified before the subcommittee on that date.

The Subcommittee Members and staff traveled to California during the week of November 30 through December 4, 1981 to participate in meetings and site visits of colocated CETA and Employment Service offices in connection with the Subcommittee's oversight of the CETA program. The Subcommittee met with CETA/ES officials and representatives in Sacramento, San Francisco and Los Angeles, California and received various recommendations for the reauthorization of future employment and training programs and revisions to the Wagner-Peyser Act.

the validity, reliability, and practicality of the adopted criteria as measures of desired performance, and evaluate the impacts of such standards (intended or otherwise) on the choice by prime sponsors of who is served, what services are provided, and the cost of such services.

TITLE V

AMENDMENTS TO OTHER STATUTES

Wagner-Peyser Act amendments

The Committee bill amends the Wagner-Peyser Act in order to achieve coordination between the job training system and the employment service system. The employment service and prime sponsors are to develop plans jointly, and then to transmit such plans to the State Employment and Training Coordinating Council. The bill provides for certification by such council similar to the requirement that community job training plans submitted by prime sponsors be certified by the council as consistent with the Governor's coordination criteria. Final approval authority is retained by the Secretary of Labor.

The Committee expects the funding and planning cycles of the job training and employment service system to have parallel time frames to the greatest extent possible. This is essential for the rational development of plans in both systems, so as to achieve an appropriate degree of coordination.

The Committee bill provides that funding allocations under the Wagner-Peyser Act for operating the employment service shall move toward a needs-based formula. In the past, there has been no statutory formula, and the administrative formula for distributing such plans has emphasized placement factors which have proven counter-productive, acting as disincentives for serving the disadvantaged and for using innovative techniques such as group job search activities.

Under the Committee bill, 90 percent of each year's funding will be distributed among the States on the basis of the prior year's allocations. The remainder would be distributed on the basis of unemployment and civilian labor force factors. The total allocations made to the states as described in the two preceding sentences would be adjusted so as to assume that no state's share would be less than 0.28 percent of such total allocations. Accordingly, the distribution formula would, in future years, reflect to a progressively greater extent each State's needs for such services in terms of statistics reflecting the numbers of potential users in the population.

The Committee bill would reserve 10 percent of Wagner-Peyser allocations for each State for use by the Governor for performance incentives, special services, and exemplary programs.

Amendments to the Work Incentive Program

The Committee bill amends the Work Incentive Program (WIN) to emphasize the provision of job search assistance services.

Under current law, the WIN program is authorized to serve program participants with a variety of employment, job search, training, and supportive services. Some participants may receive job search assistance services, while others may receive other employment and training services.

Under the Committee bill, WIN registrants will be required to participate in an intensive job search assistance program for a period of 5 to 8 weeks duration immediately following their registration in the program. For most registrants, the intensive program will consist of participation in a group job search program involving daily attendance; but, for some registrants, rigid adherence to the daily job search requirement may not be appropriate in every circumstance. A few registrants may be served through an individualized job search approach.

Limited exceptions may be made to the requirement that registrants participate in the intensive job search program. Persons who are exempted from the requirement may be offered short term services needed before they can effectively participate in the job search program. Exceptions may also be made for a temporary illness or other short-term problem.

FUNDING

The Committee bill authorizes \$5.4 billion for fiscal year 1983 and such sums as may be necessary thereafter for programs and services under the Job Training Partnership Act. The authorization includes \$3.5 billion for employment and training services for the disadvantaged; \$1 billion for services to displaced workers, \$650 million for the Job Corps, \$20 million for labor market information and \$230 million for other national programs, including programs for migrants and Native Americans.

The Committee notes that the authorization level for programs under this Act is reduced 47 percent from the 1979 level authorized by Congress for employment and training under the Comprehensive Employment and Training Act. Unemployment at that time was 5.8 percent. The national unemployment rate at the time of this report is 9.4 percent. Moreover, structural changes in the economy have increased the number of displaced workers in need of retraining and employment assistance, and the number of persons without skills entering the labor force, including minority youth, who are in need of training to compete for jobs in a technologically advanced society has grown alarmingly.

The Committee estimates that programs funded at the full authorization level would serve approximately 2,250,000 participants depending on the local mix of services. The authorized level would serve only a fraction of the eligible population, as the Congressional Budget Office (CBO) has estimated that more than 16 million persons are eligible for Title II services alone.

The Committee believes that investment in a skilled and flexible workforce is as vital to a healthy economy as investment in plant and equipment. Indeed, investment in such capital stock is dependent on skilled workers to build, operate and maintain equipment and to provide services in an increasingly complex economy. To pursue the Administration's policy of reducing public expenditures for human

ployment and Training Act shall continue to be a prime sponsor in order to provide for an orderly transition. However, two or more units designated as prime sponsors under CETA but which are located in a single labor market area must establish a joint private industry council in order to continue serving as prime sponsors. State governments serve as the prime sponsors for those States (or the balance of each State) not served by a prime sponsor which is a unit or consortium of units of general local government or a concentrated employment program (CEP).

Within the area served by the State as prime sponsor, the Governor shall designate one or more service delivery areas, establishing a private industry council for each area.

Section 102—Private industry councils

This section provides that a private industry council shall be established to be jointly responsible with the prime sponsor for planning activities under the Act. No funds under the Act shall be provided by the prime sponsor for any activity which does not have the approval of both the prime sponsor and the private industry council.

A majority of the council members shall be representatives of business and industry in each prime sponsor area, appointed from among individuals recommended by local business organizations (or whom at least one-half, whenever possible, shall be representatives of small business, including minority business). One of the private industry representatives shall be designated the initial chairman of the council. The remaining members shall be representatives of labor, education (representative of secondary, postsecondary and vocational education agencies and institutions), rehabilitation, community-based organizations, the employment service, and economic development organizations and agencies.

The membership of each council must reasonably represent the population of the area served. Members are to be appointed for fixed terms, and the prime sponsor may not dissolve the council or remove any member, except for cause.

Each prime sponsor must make a portion of its administrative costs available to enable each private industry council to hire professional, technical, and clerical staff to assist in carrying its planning and concurrence responsibilities.

In organizing and making appointments to each council, the prime sponsor shall ensure that it is eligible to be designated as a planning council for any other employment and training programs operated within areas of pervasive poverty, unemployment, and general distress.

Section 103—Performance standards

This section provides that, within 6 months after enactment, the Secretary shall establish national performance criteria based on appropriate factors including placement and retention in unsubsidized employment, increased earnings, and reduction in income support costs. In addition, factors for evaluating the performance of youth programs would take into account attainment of employability competencies, school completion, and enrollment in other training programs or apprenticeships or enlistments in the military. The Secretary would determine the adequacy of each prime sponsor's performance goals on the basis of minimum performance standards designed to recognize

Federal and State agencies. Ten percent of each State's allocation is reserved for use by the Governor for performance incentives, services for groups with special needs, and exemplary models.

The employment service plan is to be developed jointly with prime sponsors and transmitted to the State Employment and Training Coordinating Committee for certification that the plan is consistent with the Governor's coordination and special services plan under the Job Training Partnership Act. The Governor may review and propose modifications in the plan submitted to the Secretary.

Section 502—Amendments to part C of title IV of the Social Security Act

This section amends section 430 of the Social Security Act to include among those eligible for the Work Incentive Program [WIN] those who have applied for Aid to Families for Dependent Children [AFDC], in addition to those now eligible who are actual AFDC recipients.

Section 431(b) of such Act would be amended by striking out the requirement that one-third of the funds appropriated for WIN must be spent for on-the-job training and public service employment.

Section 432(d) of such Act would be amended to provide that the Secretary of Labor shall assure, to the extent possible, that WIN registrants receive employment and training services under the Job Training Partnership Act.

Section 432(f) of such Act would be amended to require the Secretary of Labor to use private industry councils in place of labor market advisory councils to advise on the availability of jobs in the areas served.

Section 433 of such Act would be amended to require all WIN registrants to participate in an intensive job search assistance program, for a period of 5 to 8 weeks, on a daily basis; and to provide for referring registrants who are not placed in unsubsidized jobs to the prime sponsor for employment and training services.

Such Act will also be amended to require joint planning with the prime sponsor under the Job Training Partnership Act.

Section 503—Repeal; transition provisions

This section provides that the Comprehensive Employment and Training Act [CETA] would be repealed as of October 1, 1982. The Secretary would be authorized to provide financial assistance in the same manner as under CETA to provide for the orderly transition of employment and training programs under the Act and also to provide for continued financial assistance for those programs.

The transition period expires September 30, 1983, as does the authority for the National Commission for Employment Policy. The records of the Commission will be transferred to the National Commission on Employment and Productivity on that date.

During the transition period, prime sponsors may consolidate program activities, establish uniform eligibility criteria, establish private industry councils, and conduct any activity authorized under the Job Training Partnership Act.

Property acquired by prime sponsors with CETA funds not transferred or made available to prime sponsors reverts to the United States.

SOCIAL SECURITY ACT

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES
TO NEEDY FAMILIES WITH CHILDREN AND FOR
CHILD-WELFARE SERVICES

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PART C—WORK INCENTIVE PROGRAM FOR RECIPIENTS OF AID UNDER
STATE PLAN APPROVED UNDER PART A

PURPOSE

SEC. 430. The purpose of this part is to require the establishment of a program utilizing all available manpower services, including those authorized under other provisions of law, under which individuals *who have applied for or are* receiving aid to families with dependent children will be furnished incentives, opportunities, and necessary services in order for (1) the employment of such individuals in the regular economy, (2) the training of such individuals for work in the regular economy, and (3) the participation of such individuals in public service employment, thus restoring the families of such individuals to independence and useful roles in their communities. It is expected that the individuals participating in the program established under this part will acquire a sense of dignity, self-worth, and confidence which will flow from being recognized as a wage-earning member of society and that the example of a working adult in these families will have beneficial effects on the children in such families.

APPROPRIATION

SEC. 431. (a) There is hereby authorized to be appropriated to the Secretary of Health, Education, and Welfare for each fiscal year a sum sufficient to carry out the purposes of this part. The Secretary of Health, Education, and Welfare shall transfer to the Secretary of Labor from time to time sufficient amounts, out of the moneys appropriated pursuant to this section, to enable him to carry out such purposes.

[(b) Of the amounts expended from funds appropriated pursuant to subsection (a) for any fiscal year (commencing with the fiscal year ending June 30, 1973), not less than $33\frac{1}{3}$ per centum thereof shall be expended for carrying out the program of on-the-job training referred to in section 432(b)(1)(B) and for carrying out the program of public service employment referred to in section 432(b)(3).]

[(c)] (b) Of the sums appropriated pursuant to subsection (a) to carry out the provisions of this part for any fiscal year (commencing with the fiscal year ending June 30, 1973), not less than 50 percent shall be allotted among the States in accordance with a formula under which each State receives (from the total available for such allotment) an amount which bears the same ratio to such total as—

(1) in the case of the fiscal year ending June 30, 1973, and the fiscal year ending June 30, 1974, the average number of recipients of aid to families with dependent children in such State during the month of January last preceding the commencement of such fiscal year bears to the average number of such recipients during such month in all the States; and

(2) in the case of the fiscal year ending June 30, 1975, or in the case of any fiscal year thereafter, the average number of individuals in such State who, during the month of January last preceding the commencement of such fiscal year, are registered pursuant to section 402(a)(19)(A) bears to the average number of individuals in all States who, during such month, are so registered.

ESTABLISHMENT OF PROGRAMS

SEC. 432. (a) The Secretary of Labor (hereinafter in this part referred to as the Secretary) shall, in accordance with the provisions of this part, establish work incentive programs (as provided for in subsection (b) of this section) in each State and in each political subdivision of a State in which he determines there is a significant number of individuals who have attained age 16 and are receiving aid to families with dependent children. In other political subdivisions, he shall use his best efforts to provide such programs either within such subdivisions or through the provision of transportation for such persons to political subdivisions of the State in which such programs are established.

(b) Such programs shall include, but shall not be limited to, (1) (A) a program placing as many individuals as is possible in employment, and (B) a program utilizing on-the-job training positions for others, (2) a program of institutional and work experience training for those individuals for whom such training is likely to lead to regular employment, and (3) a program of public service employment for individuals for whom a job in the regular economy cannot be found.

(c) In carrying out the purposes of this part the Secretary may make grants to, or enter into agreements with, public or private agencies or organizations (including Indian tribes with respect to Indians on a reservation), except that no such grant or agreement shall be made to or with a private employer for profit or with a private non-profit employer not organized for a public purpose for purposes of the work experience program established by clause (2) of subsection (b).

[(d) In providing the manpower training and employment services and opportunities required by this part, the Secretary of Labor shall, to the maximum extent feasible, assure that such services and opportunities are provided by using all authority available to him under this or any other Act. In order to assure that the services and opportunities are provided by using all authority available to him under this or any other Act. In order to assure that the services and opportunities so required are provided, the Secretary of Labor shall use the funds appropriated to him under this part to provide programs required by this part through such other Act, to the same extent and under the same conditions (except as regards the Federal matching percentage) as if appropriated under such other Act and, in making use of the programs of other Federal, State, or local agencies (public or private), the Secretary of Labor may reimburse such agencies for services rendered to persons under this part to the extent such services and opportunities are not otherwise available on a nonreimbursable basis.]

(d) In providing the training and employment services and opportunities required by this part, the Secretary of Labor shall, to the

maximum extent feasible, assure that such services and opportunities are provided by using all authority available under this or any other Act. In order to assure that the services and opportunities so required are provided, the Secretary of labor shall (1) assure, to the maximum extent feasible, that registrants under this part receive employment and training services under the Job Training Partnership Act, and (2) use the funds appropriated under this part to provide programs required by this part through such other Acts to the same extent and under the same conditions (except as regards the Federal matching percentage) as if appropriated under such other Act and, in making use of the programs of other Federal, State, or local agencies (public or private), the Secretary of Labor may reimburse such agencies for services rendered to persons under this part to the extent such services and opportunities are not otherwise available on a nonreimbursable basis.

(e) The Secretary shall take appropriate steps to assure that the present level of manpower services available under the authority of other statutes to recipients of aid to families with dependent children is not reduced as a result of programs under this part.

[(f) (1) The Secretary of Labor shall establish in each State, municipality, or other appropriate geographic area with a significant number of persons registered pursuant to section 402(a) (19) (A) a Labor Market Advisory Council the function of which will be to identify and advise the Secretary of the types of jobs available or likely to become available in the area served by the Council; except that if there is already located in any area an appropriate body to perform such function, the Secretary may designate such body as the Labor Market Advisory Council for such area.]

(f) (1) *The Secretary of Labor shall utilize the services of the private industry council for each prime sponsor (as established under the Job Training Partnership Act) to identify and provide advice on the types of jobs available or likely to become available in the area served by the prime sponsor.*

[(2) Any such Council shall include representatives of industry, labor, and public service employers from the area to be served by the Council.]

[(3)] (2) The Secretary shall not conduct, in any area, institutional training under any program established pursuant to subsection (b) of any type which is not related to jobs of the type which are or are likely to become available in such area as determined by the Secretary after taking into account information provided by the [Labor Market Advisory Council] *private industry council* for such area.

OPERATION OF PROGRAM

[SEC. 433. (a) The Secretary shall provide a program of testing and counseling for all persons certified to him by a State, pursuant to section 402(a) (19) (G), and shall select those persons whom he finds suitable for the programs established by clauses (1) and (2) of section 432 (b). Those not so selected shall be deemed suitable for the program established by clause (3) of such section 432 (b) unless the Secretary finds that there is good cause for an individual not to participate in such program. The Secretary, in carrying out such program for in-

dividuals certified to him under section 402(a)(19)(G), shall accord priority to such individuals in the following order, taking into account employability potential: first, unemployed fathers; second, mothers, whether or not required to register pursuant to section 402(a)(19)(A), who volunteer for participation under a work incentive program; third, other mothers, and pregnant women, registered pursuant to section 402(a)(19)(A), who are under 19 years of age; fourth, dependent children and relatives who have attained age 16 and who are not in school or engaged in work or manpower training; and fifth all other individuals so certified to him.】

SEC. 433. (a) (1) In carrying out this part, the Secretary shall—

(A) provide for the registration of all individuals who are required (or volunteer) to register for employment and training services under section 402(a)(19);

(B) arrange for the provision of job search assistance, including supportive services, for all such registrants to enable them to obtain employment in the regular economy;

(C) following the provision of intensive search assistance services, refer all registrants who have not been placed in unsubsidized employment to the appropriate prime sponsor for employment and training services authorized under the Job Training Partnership Act;

(D) place registrants who have not already obtained unsubsidized jobs and who are not currently being served under the Job Training Partnership Act in other employment and training activities authorized by this or by any other Act; and

(E) require all registrants to participate in the intensive job search assistance program at the times and in the manner specified in this subsection, unless the Secretary determines that the registrant should be partially or fully exempt from this participation requirement because the registrant is incapable of effectively participating in the intensive job search assistance program because of a physical, mental, or other work-impairing problem, in which case the Secretary may provide short term training (such as English language training) or other services which are determined to be essential to prepare the individual for participation in the intensive job search program.

(2) All new registrants shall be required to participate, for a period of not less than five nor more than eight weeks, in an intensive job search assistance program immediately following their registration. To the maximum extent feasible, intensive job search services shall be provided to registrants through self-directed job search or group job search activities with daily attendance of registrants. Following completion of the initial intensive job search assistance program, continuing job search assistance services may be provided at appropriate intervals to registrants. Intensive job search services shall be provided to registrants each twelve months following the completion of the initial or any succeeding intensive job search period.

(b) (1) For each State the Secretary shall develop jointly with the administrative unit of such State administering the special program referred to in section 402(a)(19)(G) a statewide operational plan.

(2) The statewide operational plan shall prescribe how the work incentive program established by this part will be operated at the local

level, and shall indicate (i) for each area within the State the number and type of positions which will be provided for training, for on-the-job training, and for public service employment, (ii) the manner in which the information provided by the [Labor Market Advisory Council (established pursuant to section 432(f))] *private industry council under the Job Training Partnership Act* for any such area will be utilized in the operation of such program, and (iii) the particular State agency or administrative unit thereof which will be responsible for each of the various activities and functions to be performed under such program. Any such operational plan for any State must be approved by the Secretary, the administrative unit of such State administering the special program referred to in section 402(a)(19)(G), and the regional joint committee (established pursuant to section 439) for the area in which such State is located.

(3) The Secretary shall develop an employability plan for each suitable person certified to him under section 402(a)(19)(G) which shall describe the education, training, work experience, and orientation which it is determined that such person needs to complete in order to enable him to become self-supporting.

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(i) *In planning for activities under this section, the administrative unit of each State shall make every effort to coordinate such activities with activities provided by the prime sponsor under the Job Training Partnership Act.*

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COMPREHENSIVE EMPLOYMENT AND TRAINING ACT

Effective October 1, 1982, the Comprehensive Employment and Training Act is repealed.

SUPPLEMENTAL VIEWS ON H.R. 5320

H.R. 5320, as reported by the full Education and Labor Committee, represents a strong effort to examine carefully the training needs of the work force and to structure a new federal employment and training program to meet those needs while seeking to avoid the main cause of failure and abuses in CETA. It is not merely "more of the same," but rather moves federal policy toward the incorporation of many of the factors that were sorely missing in previous legislation.

In substance there are many provisions which Republican Members helped formulate and we can support. These include:

Partnership with the private sector: The bill included approval authority of the plan by the private industry council; up-front planning and staffing money for the private industry council; majority representation (by business and industry) on the private industry council with the initial chairperson coming from this majority; nomination of the business and industry representatives on the council by general purpose business organizations; and joint designation with the prime sponsor of the administrative entity to carry out the program. To move participants into unsubsidized jobs is a worthy goal, but without significant participation of the private sector, this goal is difficult to achieve. The minority members support the efforts made toward greater inclusion of the private sector in H.R. 5320, and will continue to try to enhance this role during any further consideration of the bill.

Increase in service delivery area size—labor market area concept: Support for training programs must come from all segments of the community. If too many service deliverers depend on public and private resources for support, the effort becomes divisive. Additionally, the focus of training efforts must include area labor market demands. For these reasons, the Minority Members are pleased with the provisions in the bill that increase the service delivery area population size to 150,000 and relate this population base to the labor market area concept.

Elimination of job creation/public service employment: This bill as originally introduced included provisions for wage subsidization in the public sector and for a countercyclical job creation program. Through the efforts of the Minority, these provisions were eliminated from the bill. The Minority believes that this bill must be true to its intent, that is, as a training measure not a job creation bill.

Role of the State: There are many training related functions that are the authority of the State. H.R. 5320 requires State level coordination of the training programs under this bill with those of vocational education, employment services, work incentive programs, and general education programs. This coordination is not only structural, but programmatic. Without such coordination, the overall effect of training

programs is diminished and the potential for duplication of effort is exacerbated. The Minority Members of the Committee agree that one of the strengths of a State role in training is that of coordination. The Minority will continue to look for ways to strengthen the role of the State in order to maximize the effective utilization of resources available under this Act.

Role of Education: Much of the training that prepares youth and adults for entry into the job market is provided through the local education agencies. Employers often state that what they need are employees who possess basic reading, writing and computational skills. This bill incorporates a strong, yet appropriate, role for education, which Republican Members of the Committee have been advocating for years. Twenty percent of the funds for the State may be used for assistance to State education agencies to facilitate structural coordination within training activities.

Additionally, a State incentive grant for joint agreements between prime sponsors and State and local education and training agencies which contribute matching funds is established to provide programmatic coordination. The relationship between education and training has always been a critical one, and the Minority Members advocate the role for education that has been included in this bill.

Strong Youth Training Component: The Republican Members of the Education and Labor Committee traditionally have maintained strong support for youth training programs. Fifty percent of the funds that are available to prime sponsors for training under this bill, adjusted for variation in the proportion of youth in the area, are reserved for in-school and out-of-school youth. The suggested programs for youth build upon what has been learned through the youth demonstration projects and take a developmental approach to the unemployment problems youth face.

Displaced Workers Program: There are areas of this country that face severe training problems due to the displacement of workers. These problems in many areas will persist even after national economic recovery because of inevitable changes in industry and technology. This bill offers a means by which funds can be directed toward the provision of appropriate training and placement assistance for such workers. The funds are targetted in two ways, by formula and by application, and an adjusted match is required. Republican Members recognize the need for such a program and favor the inclusion of it in an overall Federal training policy.

Despite the many strengths of this bill, Republican Members are keenly aware of remaining areas of disagreement. Only glaring problem with the bill is the authorization level of \$5.4 billion. We strongly believe that our responsibility as Members of the authorizing committee is to establish the framework for Federal programs that are defensible and meet the needs of the eligible participants. It is the responsibility of the Appropriations Committee to establish the allocation for this program within the context of the economy and the need for a responsible Federal budget. The Republicans attempted to change the authorization level included in the bill to "such sums as necessary," but were not successful.

A specific authorization level in this bill is misleading. It creates a false expectation that the total amount will be appropriated, which appears extremely unlikely. An appropriation must be made within the context of the needs of other programs and economic and budgetary determinants.

JOHN N. ERLNBORN.
WILLIAM F. GOODLING.
LAWRENCE J. DENARDIS.
WENDELL BAILEY.
JAMES M. JEFFORDS.
E. THOMAS COLEMAN.
ARLEN ERDAHL.
MILLCENT FENWICK.
EUGENE JOHNSTON.
LARRY E. CRAIG.

TRAINING FOR JOBS ACT

JUNE 9 (legislative day, JUNE 8), 1982.—Ordered to be printed

Mr. HATCH (on behalf of Mr. QUAYLE), from the Committee on Labor and Human Resources, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany S. 2036]

The Committee on Labor and Human Resources, to which was referred the bill (S. 2036) to provide for a job training program and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

THE NEED FOR LEGISLATION

The authorization of the Comprehensive and Training Act expires this year. This nation needs a new job training program for the drop-out youth who are not prepared for employment, for welfare recipients who need training to escape from dependency, for the economically disadvantaged who cannot compete in the labor market without help. We also need a training program for the dislocated worker who needs new skills for the new jobs being created by the changing economy. The federal government has a responsibility to help meet these training needs.

New legislation must be based on four basic principles which are essential for an effective job training program. These principles are:

First, the new legislation must provide for the involvement of the private sector in the design and administration of training pro-

tion at the state level for fund distribution and, therefore has provided that 25 percent of the funds not be suballocated so as to be available to the Governor for state-wide programs and administration. The remaining 75 percent of the funds will be distributed to substate service delivery areas on a formula basis, again, using labor force participation as the determinant.

Further amendments allow for use of funds for advertising in newspapers only for jobs paying less than twice the minimum wage and specifically permits the referral of an applicant to private employment agencies as long as the applicant is not charged a fee. The committee is of the opinion that all sources of job information and assistance should be available to applicants and the federally funded agencies should not be discouraged from working closely with all aspects of the private sector.

The Committee has also provided that funds appropriated for the Employment Service shall be used for applicant and employer employment-related activities and not for other purposes. Should the Secretary of Labor prescribe the use of the Employment Service for other purposes, such as alien certification, such costs are to be fully reimbursed by the Secretary from other than Employment Service funds authorized under the provisions of this Act.

TITLE V—DISLOCATED WORKERS

The Committee recognizes the need to be responsive to the plight of the growing number of displaced workers—workers who have no reasonable expectation to return to jobs from which they have been or are about to be laid off. During hearings on unemployment in the automobile industry held by the Subcommittee on Employment and Productivity in January, 1982, it was brought to the attention of the Subcommittee that by 1985 as many as 500,000 auto and auto-related jobs will be eliminated. The effects of such massive displacement of workers due to technological change or changes in consumer demand has far reaching effects on individual workers, their families, their communities and the nation as a whole. These are workers that have little likelihood of being recalled to their previous jobs or even their previous industry as the economy gets better. They have job skills that are no longer marketable—no longer in demand. The Committee is concerned about and aware of the inordinate drain on unemployment compensation and other forms of public assistance and the economic repercussions of these displaced workers, but equally important is the concern for the personal impact of long term, seemingly hopeless unemployment for persons that have been effective, productive and strong contributors to the nation's economy.

In order to facilitate the movement of these workers into jobs for which demand exceeds supply, this legislation authorizes a comprehensive program of training and employment services to displaced workers. The program will provide assistance for job search, job development, training in job skills for which demand exceeds supply, supportive services, relocation assistance and programs conducted in cooperation with employers or labor organizations to provide early intervention in the event of a plant closure.

The bill provides for the States to identify workers who have been laid off and are eligible for, or have exhausted their entitlement to unemployment compensation and who are unlikely to return to their previous positions. States are to determine what job opportunities exist within the labor markets, or outside such areas, for which workers could be retrained. The States are then to bring the workers and the necessary training programs together with the goal of them matching the trained worker with the job openings.

The program will be administered at the state level with assistance from the local private industry councils. To encourage local participation the bill provides applicants be given an opportunity to apply for funding of locally developing projects that meet the provisions of the title. Also, the Committee recognizes the value of labor organization involvement and support in directing programs for displaced workers and encourages that input by providing such labor organizations the right of full consultation in programs affecting substantial numbers of their membership.

The Committee bill includes a provision which allows funds appropriated for this program be used to pay 50 percent of the cost of the program. The remaining 50 percent shall consist of matching funds from non-federal sources. It is expected the match will consist of private, state or local moneys or any combination of these.

The matching provision allows flexibility for those areas experiencing severe unemployment. For any State whose unemployment is at least one percentage point above the national average for the twelve month period before the Secretary makes allocation for a fiscal year, the non-Federal matching requirement is reduced by 10 percentage points for every percent that the State unemployment rate exceeds the national average. Two points need to be emphasized: First, the reduced non-Federal match in no way increases the Federal cost nor does it increase the State's allocation. It only reduces the amount of the required non-Federal contribution. Second, the required matching rate is to be determined before the start of the fiscal year and will not be changed during that fiscal year regardless of changes in State or Federal unemployment rates.

In order to encourage laid off workers to participate in training programs authorized under this title while they are receiving unemployment benefits and, therefore, possibly shorten the duration of their unemployment, the bill allows for participants to continue to be eligible for unemployment compensation while participating in the authorized training.

The Committee bill provides for the distribution of funds appropriated to States by formula based on the number of long-term unemployed in the State. It is intended that the funds be used expeditiously for the purpose intended; if that is not the case, provisions allow for the Secretary of Labor to reallocate the funds to other States which have shown a demonstrated need for the funds.

The Committee also adopted an amendment specifying that not more than 30 percent of the funds available in any State for this Title be used for the combined costs of administration and supportive services and specifying that none of the Federal funds under the title be used for the payment of wages to participants. This does not, of course, preclude the normal use of on-the-job training

contracts in which an employer's training cost is determined by reimbursing him for a percentage of the wages paid to trainees.

TITLE VI—COORDINATION OF JOB TRAINING ACTIVITIES

This Title is designed to remove some of the existing barriers to coordination among Federally funded job training activities. Traditionally, Federal job training laws have mandated both specific advisory committees and separate administrative structures thus impeding the legitimate desires of the States for more control over their own administrative structure. This Title is designed to restore to the States more discretion in these areas.

The first two sections of the Title deal with advisory committees. The first section authorizes the use of the private industry council as an advisory body for any person established under Federal job training laws. The second authorizes the Governor to combine two or more advisory councils (or their functions) related to job training provided that "the essential elements relating to composition" of each of the councils are preserved. The Committee intends this phrase to receive a liberal interpretation so that the purposes of the Title can be achieved. It has made the decision of the Governor to combine councils or functions subject to review, in the first instance, by the head of the administering agency, but permits appeal by the Governor to the Director of OMB because it believes that the Director may be more receptive to the advantages of combination and the needs of the Governor.

The last section applies the principles of the Economy Act to State agencies receiving Federal financial assistance for job training. Under that Act, one Federal agency may perform the work of another if it is determined to be in the interest of the government to do so. There is no reason why that flexibility should not apply at the state level as well as on the Federal. The purpose of this provision is to give the Governor the flexibility to organize administration in his State on the basis of economy and efficiency.

TITLE VII—SUMMER YOUTH EMPLOYMENT AND TRAINING PROGRAMS

The Committee recognizes the need for youth employment and training activities during the summer months. It understands that for a significant number of participants, summer programs contribute not only to making at least a nominal contact with the job market, but may have a significant impact on their ability to continue their education.

Title VIII provides for allocations to states and suballocations to service delivery areas to be planned for and administered under the same provisions as the Title I programs. Persons eligible for participation in the Summer Youth program are those economically disadvantaged who have not yet reached age 22.

Although the Committee bill provides for the programs to be planned and administered in accordance with the provisions of Title I, the Committee intent is clear that the program is not subject to the financial limitations included in Title I regarding restrictions on support services and on the payment of wages, allowances and stipends.

JOB TRAINING PARTNERSHIP ACT

SEPTEMBER 28, 1982.—Ordered to be printed

Mr. PERKINS, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 2036]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2036) to provide for a job training program and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Job Training Partnership Act".

TABLE OF CONTENTS

- Sec. 1. Short title; table of contents.*
- Sec. 2. Statement of purpose.*
- Sec. 3. Authorization of appropriations.*
- Sec. 4. Definitions.*

TITLE I—JOB TRAINING PARTNERSHIP

PART A—SERVICE DELIVERY SYSTEM

- Sec. 101. Establishment of service delivery areas.*
- Sec. 102. Establishment of private industry council.*
- Sec. 103. Functions of private industry council.*
- Sec. 104. Job training plan.*
- Sec. 105. Review and approval of plan.*
- Sec. 106. Performance standards.*
- Sec. 107. Selection of service providers.*
- Sec. 108. Limitation on certain costs.*

The Senate bill has no comparable provision.

The Senate recesses.

The House amendment prohibits the Council from directly operating or providing services to eligible participants.

The Senate bill has no comparable provision.

The Senate recesses.

The Senate bill requires the Council to propose service delivery areas, to develop performance standards, and to review and provide written comments on the State plan for the State employment service agency.

The House amendment has no comparable provision.

The House recesses.

The House amendment requires the council to (1) identify the employment and training and vocational education needs throughout the State and the extent to which Federal, State, and local programs and services adequately meet such needs; (2) comment on reports required by section 105(d)(3) of the Vocational Education Act of 1963; (3) review plans of all State agencies providing employment, training, and related services, and provide comments and recommendations to the Governor, to appropriate State officials, and to appropriate Federal agencies; (4) assume the functions of any State coordinating committee for the WIN program.

The Senate bill has no comparable provisions.

The Senate recesses.

The House amendment requires the state to submit a biennial governors' coordination and special services plan to the Secretary which establishes criteria for coordinating activities under this Act with related programs and services.

The Senate bill has no comparable provisions.

The Senate recesses with an amendment to require the Secretary to approve the plan unless he finds the plan to be in violation of specific provisions of this Act, and to specify that coordination criteria established in the plan cannot restrict or modify the provisions of this Act relating to eligibility requirements or selection of service deliverers.

ADULT/YOUTH PROGRAM ACTIVITIES

The Senate bill has a generalized statement of functions for which funds may be used which include any job training activity designed to prepare disadvantaged persons for, and place them in, employment.

The House amendment has detailed statements of the uses of funds for adult training programs and for youth preparatory programs. Individual notes identify uses authorized under the House amendment which would not be included in the general authority of the Senate bill.

The House amendment describes education for employment activities for eligible youths who have not obtained a high school diploma or who have educational deficiencies.

The Senate bill has no comparable provisions.

The House amendment provides for pre-employment skills training for youth aged 14 through 19, with priority given to those youths who do not meet established levels of academic achieve-

The Senate bill authorizes a loan fund to be used by economically disadvantaged participants to provide the expenses for basic necessities.

The House amendment has no comparable provision.

The Senate recedes.

The Senate bill prohibits the use of funds for allowances, stipends, wages or public service employment.

The House amendment authorizes allowances and wages as detailed in the notes below.

The House recedes with an amendment to prohibit public service employment under this Act and to delete the prohibition on wages, allowances and stipends as specified in the waiver provision.

The House amendment provides for subsistence allowances based on family income, but not to exceed the minimum wage; participation cost stipends; and lump sum payments or other rewards for completion of training or other constructive attainments.

The Senate recedes with an amendment to base allowances on locally developed needs based formulas.

The House amendment provides that a trainee shall receive no allowances for hours in which he failed to participate without good cause. No comparable Senate provision.

The Senate recedes with an amendment to specify that a trainee shall not receive allowances for training activities in which the trainee fails to participate without good cause.

The House amendment provides that individuals employed shall be paid wages which shall not be less than the higher of the Federal minimum wage, the minimum wage under the applicable State or local minimum wage law, or the prevailing rates of pay individuals employed in similar occupations by the same employer. No comparable Senate provision.

The Senate recedes.

The House amendment provides that stipends and allowances shall not be considered income for the purposes of determining eligibility for income transfer programs. No comparable Senate provision.

The House amendment provides that earnings and allowances received by any youth participating in a program under the Act shall be disregarded in determining the eligibility of the youth's family for, and the amounts of benefits based on needs under, any Federal or federally assisted programs. No comparable Senate provision.

The Senate recedes with an amendment to limit this provision relating to allowances to programs not under the Social Security Act. The Conference agreement also provides for a limited disregard of allowances provided under this Act under the AFDC program.

The House amendment provides that all individuals participating in training shall be eligible to receive allowances, but not for a period to exceed 104 weeks in any 5-year period. No comparable Senate provision.

The House recedes.

The House amendment provides that no individual may participate in a program for more than 30 months in any 5-year period.

The House recedes.

The House amendment limits eligibility to those residing in the prime sponsor's area, except in the case of two or more prime sponsors operating with a joint private industry council in which case residents in any such prime sponsor area shall be eligible.

The Senate bill has no comparable provision.

The Senate recedes with an amendment to permit the local job training plan to provide for a limited waiver of the residency requirement.

SERVICE PRIORITIES

The Senate bill provides that at least 50 percent of the funds excluding summer youth shall be used for persons who have not attained age 25.

The House amendment provides that 50 percent of the funds including summer youth shall be used for youth under the age of 22.

The House recedes with an amendment to exclude the summer youth programs from the division of funds between adult and youth programs. The summer youth program is separately authorized as Part B. At least forty percent of the funds allocated under Part A shall be used for eligible youth under the age of 22. This percentage may be adjusted by the Senate adjustment factor. It is clearly not the intent of the conferees to reduce support for youth participation in the programs under this title. By accepting the lower age limit definition from the House amendment and removing the summer youth programs from the percentage split of funds, as in the Senate bill, the conferees believe that at least the current level of support for all youth programs will be maintained. Additionally, the conferees recognize that individuals aged 22 through 25 face special employment barriers in the labor force, and therefore encourage close examination of the needs of this age cohort in the development of programs at the service delivery level.

The House amendment provides that 15 percent of the funds available for adults may be used for services to youth and 15 percent of the funds available for youth may be used for adults.

The Senate bill has no comparable provision.

The House recedes.

The Senate bill required for proportionate service to recipients of AFDC and eligible school drop-outs.

The House amendment has no comparable provision.

The House recedes with an amendment to serve AFDC recipients and high school dropouts on an equitable basis taking into account their proportion to the eligible population based on the best available data.

The Senate bill provides that 10 percent of the funds may be used for persons who are not economically disadvantaged but have other labor market disadvantages.

The House amendment specifies that 10 percent of the participants may be persons who are not economically disadvantaged, if they have other barriers to employment.

The Senate recedes with an amendment to include handicapped who do not meet the income eligibility criteria in the ten percent income eligibility "window".

ceiving Federal financial assistance for job training or related programs.

The House amendment has no comparable provision.

The Senate recedes.

The Senate bill amends the Act of May 21, 1920 (commonly known as the Economy Act) to authorize each State agency to contract with any other State agency to perform federally funded job training services, if the Governor determines this will promote efficiency.

The House amendment has no comparable provision.

The Senate recedes.

SUMMER YOUTH

The Senate bill authorizes such sums as may be necessary for a summer youth employment and training program.

The House amendment authorizes summer employment and training programs as a permissible activity under the general employment and training program for the economically disadvantaged.

The House recedes with an amendment to assure that summer youth programs are consistent with the conference agreement regarding adult/youth activities.

The Senate bill provides for a formula distribution of the funds among States, service delivery areas and Native American programs.

The House amendment has no comparable provision.

The House recedes.

The Senate bill provides a list of allowable activities for the Summer Youth program.

The House amendment has no comparable provision.

The House recedes.

The Senate bill specifies that eligible participants shall be under the age of 22.

The House amendment specifies in section 261(a) that eligible participants shall be aged 16 through 21 and section 261(c) permits eligible youth aged 14 or 15 to participate, if appropriate, and set forth in the community job training plan.

The Senate recedes.

The Senate bill amends the Community Services Block Grant Act to provide the Secretary of Health and Human Services with the authority to designate another public or private nonprofit agency to administer community action programs in any case in which a community action agency is denied refunding or is terminated for cause.

The House amendment has no comparable provision.

The Senate recedes.

The House amends the WIN program to: (1) utilize the services of the PIC to identify and provide advice on the types of jobs available or likely to become available instead of the Labor Market Advisory Council; (2) require intensive job search assistance for AFDC recipients, and (3) require coordination of WIN activities with activities provided by the prime sponsor under the Job Training Partnership Act.

The Senate bill has no comparable provision.

The Senate recedes with amendments authorizing, instead of requiring, intensive job search assistance including group job search activities.

The House amendment insures that each individual participating in any program established under this Act, or receiving any assistance or benefit under this Act, has not violated section 3 of the Military Selective Service Act by not presenting and submitting to registration as required pursuant to such section. The Director of the Selective Service System shall cooperate with the Secretary in carrying out this section.

The Senate bill has no comparable provision.

The Senate recedes.

CARL D. PERKINS,
AUGUSTUS F. HAWKINS,
WILLIAM D. FORD,
WILLIAM CLAY,
MARIO BIAGGI,
PAUL SIMON,
BALTASAR CORRADA,
HAROLD WASHINGTON,
JOHN N. ERLNBORN,
JAMES M. JEFFORDS,
THOMAS E. PETRI,
MILLICENT FENWICK,
LAWRENCE J. DENARDIS,

Managers on the Part of the House.

ORRIN G. HATCH,
DAN QUAYLE,
PAULA HAWKINS,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,

Managers on the Part of the Senate.

○

Finder's Aid
P.L. 97-375 (96 Stat.1819) Approved December 21, 1982
"Congressional Reports Elimination Act of 1982"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H. Rep. 97-804</u>
Elimination of Certain Reports to Congress (Technical Amendment)	1120(a) Redesignated as 1120	107(a)	1820	23
Elimination of Requirement for Report to Congress on Certain Study Projects	1120(b) Stricken	107(a)	1820	7, 23

Public Law 97-375
97th Congress

An Act

To discontinue or amend certain requirements for agency reports to Congress.

Dec. 21, 1982
[H.R. 6005]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Congressional Reports Elimination Act of 1982".

Congressional
Reports
Elimination Act
of 1982.

TITLE I—ELIMINATIONS

REPORTS BY MORE THAN ONE AGENCY

SEC. 101. (a) Section 616(b) of the Act of December 15, 1980, entitled "An Act making appropriations for agriculture, rural development, and related agencies programs for the fiscal year ending September 30, 1981, and for other purposes" (31 U.S.C. 28(b); 94 Stat. 3117), is repealed.

31 USC 1114
note.

(b) Section 126(b) of the Military Construction Act of 1981 (31 U.S.C. 28, note; 94 Stat. 1869) is repealed.

31 USC 1114
note.

REPORT BY THE EXECUTIVE OFFICE OF THE PRESIDENT

SEC. 102. Section 6002(g) of the Solid Waste Disposal Act (42 U.S.C. 6962(g)) is amended to strike everything after the word "resources" and to insert in lieu thereof a period.

REPORTS BY THE DEPARTMENT OF AGRICULTURE

SEC. 103. (a) Section 1303(d) of the Food and Agriculture Act of 1977 (7 U.S.C. 2011, note; 91 Stat. 980) is repealed.

(b) Paragraph (a) of the Act of March 4, 1913, entitled "An Act making appropriations for the Department of Agriculture for the fiscal year ending June thirtieth, nineteen hundred and fourteen" (16 U.S.C. 502; 37 Stat. 843), is amended by striking out the second sentence.

(c) Section 9 of the Soil Conservation and Domestic Allotment Act (16 U.S.C. 590i; 50 Stat. 329) is amended by striking out the third sentence.

REPORTS BY THE DEPARTMENT OF DEFENSE

SEC. 104. (a) Section 1081 of title 10, United States Code, is amended by striking out the second sentence.

(b) Section 2677(c) of title 10, United States Code, is repealed.

(c) Section 2110(b) of title 10, United States Code, is amended by striking out "The Secretary of each military department shall report to Congress in April of each year on the progress of the flight instruction program."

REPORT BY THE DEPARTMENT OF EDUCATION

SEC. 105. Section 112(b)(3) of the Rehabilitation Act of 1973 (29 U.S.C. 732(b)(3); 87 Stat. 372) is repealed.

REPORTS UNDER THE DEPARTMENT OF ENERGY

SEC. 106. (a) Section 203 of the Clean Air Act Amendments of 1977 (42 U.S.C. 7551) is amended by—

(1) striking out subsection (b); and

(2) striking out the subsection designator “(a)”.

(b) The Electric and Hybrid Vehicle Research, Development and Demonstration Act of 1976 is amended by striking out the last sentence of section 7(e)(1) (15 U.S.C. 2506(e)(1)).

15 USC 3803.

(c) Section 4(c)(8) of the Methane Transportation Research, Development, and Demonstration Act of 1980 (15 U.S.C. 3808(c)) is amended by striking out “and report to the Congress on”.

Repeal.

(d) Section 742 of the Powerplant and Industrial Fuel Use Act of 1978 (42 U.S.C. 8452) is repealed.

REPORTS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SEC. 107. (a) Section 1120(b) of the Social Security Act (42 U.S.C. 1320) is amended by striking out subsection (b) and by striking out “(a)”.

(b) Section 329(f)(5) of the Public Health Service Act (42 U.S.C. 254b(f)(5)) is amended by striking out the last sentence.

REPORTS BY THE DEPARTMENT OF THE INTERIOR

SEC. 108. (a) Section 4 of the joint resolution of August 14, 1976, entitled “Joint resolution providing for Federal participation in preserving the Tule Elk population in California” (16 U.S.C. 673g; 90 Stat. 1189), is amended by striking out the final sentence thereof.

Repeal.

(b) Section 3 of the Act of August 21, 1951 (25 U.S.C. 673; 65 Stat. 195) is repealed.

(c) The Tribally Controlled Community College Assistance Act of 1978 is amended by striking out subsection (e) of section 106 and the last sentence of subsection (c)(2) of section 107 (25 U.S.C. 1807(e) and 1808(c)(2); 92 Stat. 1327).

(d) Section 208 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458d; 88 Stat. 2216) is amended by striking out the last sentence.

REPORTS BY THE DEPARTMENT OF JUSTICE

SEC. 109. (a) Section 4352(b) of title 18, United States Code (88 Stat. 1141), is repealed.

Repeal.

(b) Section 203 of the Truth in Lending Act (18 U.S.C. 891, note; 82 Stat. 162) is repealed.

REPORTS BY THE DEPARTMENT OF LABOR

SEC. 110. (a) Section 6(f) of Public Law 90-83 (29 U.S.C. 606; 81 Stat. 221) is repealed.

(b) Section 41(b)(1) of the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 941(b)(1); 72 Stat. 835) is amended by striking out “and from time to time make to Congress such recom-

guidance of the Office and with the cooperation of the Director of the National Science Foundation, with appropriate assistance from other Federal departments and agencies as the Office or the Director of the National Science Foundation deems necessary. The report shall include—

“(1) a statement of the President’s current policy for the maintenance of the Nation’s leadership in science and technology;

“(2) a review of developments of national significance in science and technology;

“(3) a description of major Federal decisions and actions related to science and technology that have occurred since the previous such report;

“(4) a discussion of currently important national issues in which scientific or technical considerations are of major significance;

“(5) a forecast of emerging issues of national significance resulting from, or identified through, scientific research or in which scientific or technical considerations are of major importance; and

“(6) a discussion of opportunities for, and constraints on, the use of new and existing scientific and technological information, capabilities, and resources, including manpower resources, to make significant contributions to the achievement of Federal program objectives and national goals.

“(b) The Office shall insure that the report, in the form approved by the President, is printed and made available as a public document.”; and

Public
availability.

(4) in section 205(a)(11), insert “and the Congress” after “President”.

42 USC 6614.

REPORT BY THE VETERANS’ ADMINISTRATION

SEC. 216. Section 4142(h)(4) of title 38, United States Code, is amended by striking out the following “together with a summary of the reasons that such scholarships were not accepted”.

Approved December 21, 1982.

LEGISLATIVE HISTORY—H.R. 6005 (S. 2258):

HOUSE REPORT No. 97-804 (Comm. on Government Operations).

CONGRESSIONAL RECORD, Vol. 128 (1982):

Sept. 20, considered and passed House.

Dec. 8, considered and passed Senate.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 18, No. 51:

Dec. 21, Presidential statement.

CONGRESSIONAL REPORTS ELIMINATION ACT OF 1982

SEPTEMBER 14, 1982.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

Mr. BROOKS, from the Committee on Government Operations,
submitted the following

REPORT

[To accompany H.R. 6005]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Operations, to whom was referred the bill (H.R. 6005) to discontinue or amend certain requirements for agency reports to Congress, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in *italic type* in the reported bill.

EXPLANATION OF COMMITTEE AMENDMENT

H.R. 6005 was reported by the Government Operations Committee with an amendment in the nature of a substitute. The entire text of this report is an explanation of the amendment.

SUMMARY AND PURPOSE

As reported by the House Committee on Government Operations, H.R. 6005 will eliminate, consolidate, simplify, or reduce some 77 recurring congressionally-mandated reporting requirements. Congressional committees with substantive jurisdiction over the subject matter covered by these reporting requirements have concurred in this action.

H.R. 6005 was introduced at the request of the Office of Management and Budget. As originally introduced, it was a compilation of approximately 200 reports which departments and agencies in the Executive Branch had recommended for elimination or modification. The deletion by the Government Operations Committee of a number of provisions is the result of recommendations received from Committees of the House of Representatives. Provisions were deleted because committees indicated the reports are either still useful and pertinent in

overseeing government programs and activities or they contain substantive material which should be the subject of in-depth hearings by the relevant committees prior to any change in the law.

COMMITTEE ACTION AND VOTE

On August 10, 1982, the bill, as amended, was ordered reported unanimously by the full committee on a voice vote, a quorum being present.

HEARING

The Legislation and National Security Subcommittee of the Committee on Government Operations held a hearing on H.R. 6005 on July 29, 1982. Testifying in favor of the legislation were Christopher C. DeMuth, Administrator of the Office of Information and Regulatory Affairs at the Office of Management and Budget, who presented the Administration's views, and Arthur Corazzini, Deputy Director of the Program Analysis Division at the General Accounting Office.

Mr. DeMuth linked the OMB efforts to reduce congressionally-mandated reporting requirements to provisions of the Paperwork Reduction Act of 1980, which, as stated by Mr. DeMuth, requires the OMB to:

Examine the entire life cycle of Federal information activities, from the actual collection of information, through its maintenance and use, and ultimately to its dissemination.

Mr. DeMuth indicated that it is necessary to eliminate or reduce congressional reporting requirements. He said:

As Executive Branch agencies face budgetary and personnel reductions, the administrative burdens created by adding reporting requirements become quite significant. Moreover, the time and costs associated with the preparation of these reports often distract agencies from their executive functions.

Arthur Corazzini, testifying for the General Accounting Office, outlined efforts of the GAO to accomplish reports reduction. Corazzini indicated that a central data bank has been established in the GAO for monitoring the various reporting requirements of the Congress. This comprehensive inventory is available through the GAO Congressional Sourcebook Services and the Congressional Research Service's SCORPIO system. Corazzini suggested that if the utility of congressional reports were monitored and evaluated on an ongoing basis, the Congress could more easily identify unneeded reports that should be eliminated. He encouraged drafters of legislation to carefully assess the value of reporting requirements during the legislative initiation and reauthorization processes and to use the GAO's inventory of reporting requirements to determine what information already is available in order to avoid unnecessary creation of new requirements.

GENERAL DISCUSSION

At the present time there are approximately 2,900 congressionally mandated recurring reporting requirements, according to the General

vehicles, together with all relevant information in support thereof, and to report whether such purchase or lease would, with high probability, displace the normal levels of private procurement of such vehicles for use in the United States.

Section 106(c)

Deletes the requirement that the Secretary of Energy report to Congress on any changes in fuel supply patterns, tax policies and standards governing the manufacture of vehicles which are needed to facilitate the manufacture and use of methane-fueled vehicles.

Section 106(d)

Deletes the requirement that the Secretary of Energy, in conjunction with fourteen other agencies, submit a report on Coal Industry performance and competition.

Section 107(a)

Repeals the requirement that the Secretary of Health and Human Services submit an annual report to Congress describing any research, demonstration or similar project approved with full Federal financing under the Social Security Act including a statement of purpose, probable cost and expected duration of each project.

Section 107(b)

Deletes requirement that the Secretary of Health and Human Services annually report on the amounts of grants to migrant health centers expended for improvements to private property under the migrant health program.

Section 107(c)

Deletes the requirement that the Secretary of Health and Human Services report annually on the status of handicapped children in the Head Start programs, including the number of children being served, their handicapping conditions and the services being provided such children.

Section 108(a)

Deletes the requirement that the Secretary of the Interior's annual report include a description of the development and implementation of plans for Tule elk restoration and conservation.

Section 108(b)

Repeals the requirement that the Secretary of the Interior annually report on activities and expenditures associated with funds deposited in the Treasury for the use of the Ute Indian Tribe.

Section 108(c) (1)

Deletes the requirement that the Secretary of the Interior annually report on the current status of tribally controlled community colleges, and

(2) Deletes requirement that the Secretary of the Interior annually report on funds provided to tribal organizations which control and manage any previously private school.

Section 109(a)

Deletes the requirement that the National Institute of Corrections submit a comprehensive and detailed annual report of its operations

[(6) United States and international reserves and resources, and

[(7) likely future metallurgical technologies.

[(e) REPORTS.—(1) Pursuant to the provisions of the preceding subsections of this section, the Secretary shall submit to the President for transmittal to the Congress such interim reports as he deems advisable and, not later than 18 months after the effective date of this Act, a comprehensive and final report to the Congress containing the findings with respect to such study and investigation. Such reports may include such legislative and administrative recommendations as the President deems advisable.

[(2) Before submitting a report to the Congress under paragraph (1), the President shall—

[(A) publish in the Federal Register a notice and summary of the proposed report and make copies of such report available and afford interested persons an opportunity (of not less than 90 days' duration) to present written comments; and

[(B) make such modifications of such report as he may consider appropriate on the basis of such comments.

[(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary for allocation between the Department of Energy and the other agencies participating in the study under this section for the fiscal years 1979 and 1980, not to exceed \$18,000,000 to carry out the provisions of this section.]

SECTION 1120 OF THE SOCIAL SECURITY ACT

APPROVAL OF CERTAIN PROJECTS

SEC. 1120. [(a)] No payment shall be made under this Act with respect to any experimental, pilot, demonstration, or other project all or any part of which is wholly financed with Federal funds made available under this Act (without any State, local, or other non-Federal financial participation) unless such project shall have been personally approved by the Secretary or Under Secretary of Health, Education, and Welfare.

[(b) As soon as possible after the approval of any project under subsection (a), the Secretary shall submit to the Congress a description of such project including a statement of its purpose, probable cost, and expected duration.]

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * *

Finder's Aid
P.L. 97-377 (96 Stat. 1830) Approved December 21, 1982
Continuing Appropriations for Fiscal Year 1983

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-959</u>	<u>HCRep. 97-980</u>
State Supplementary Payments-- Agreement as to Level of Payments--Eligibility for Medicaid Funds	1618(c) New	147	1917	--	--

PUBLIC LAW 97-377—DEC. 21, 1982

***CONTINUING APPROPRIATIONS FOR
FISCAL YEAR 1983**

section shall be construed as barring the Copyright Royalty Tribunal from expending funds to decide, and to issue written materials with regard to its Docket Number 81-2, and to defend in court or elsewhere its decisions, orders, memoranda, or opinions in such docket or relating to the subject matter of such docket.

Nothing in this joint resolution shall inhibit the Library of Congress and the Copyright Office from expending funds duly appropriated for the general purpose of administering the Copyright Act, including the compulsory licensing provisions therein, except as solely and specifically related to implementation of the Copyright Royalty Tribunal's rate determination of October 20, 1982 as set out in 47 FR 52146 (November 19, 1982) until the Court of Appeals has rendered a final decision regarding said determination as it relates to the distant signal rate adjustment.

17 USC 101 *et seq.*

SEC. 144. Notwithstanding any provision of this joint resolution or any other law or regulation, payments for local educational agencies under the Act of September 30, 1950 (Public Law 874, 81st Congress) in Montana for fiscal year 1983 shall be computed from corrected 1981 financial data. The provisions of this section shall not apply unless the following conditions are met:

20 USC 236.

(1) No such payments shall be made until an audit is conducted. (2) No such payments shall be made prior to March 30, 1983. (3) The total amount of the increase in payments made by reason of this section shall not exceed \$3,000,000. (4) No such payments shall be made prior to the submission of the audit report to the Committee on Appropriations of the Senate and of the House of Representatives.

SEC. 145. Notwithstanding any other provision of this joint resolution, section 5546a(a) of title 5, United States Code, is amended (1) by deleting the period at the end of paragraph (2) of subsection (a) and inserting in lieu thereof a semicolon and the word "and", and (2) by inserting immediately after paragraph (2) of subsection (a) the following new paragraph:

"(3) any employee of the Federal Aviation Administration who occupies a position at the Federal Aviation Administration Academy, Oklahoma City, Oklahoma, the duties of which are determined by the Administrator to require the individual to be actively engaged in or directly responsible for training employees to perform the duties of a position described in subparagraph (a); (b); or (c) of this subsection, and who, immediately prior to assuming such position at such Academy, occupied a position referred to in subparagraph (a), (b), or (c) of paragraph (1) of this subsection."

SEC. 146. No funds, including funds provided in this joint resolution or in the account entitled "Expenses, Disposal of Surplus Real and Related Personal Property" (Account No. 47-5254-0-2-804), may be expended by the General Services Administration to proceed with any sale or disposal of real property and improvements known as the Naval and Marine Corps Reserve Center at Beaver-tail Point, Jamestown, Rhode Island, containing 6.81 acres, more or less, and identified by General Services Administration control number N-RI-482A.

SEC. 147. Section 1618 of the Social Security Act is amended by adding the following new subsection:

42 USC 1382g.

"(c) The Secretary shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its, supplementary payments for

any portion of the period July 1, 1980 through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976 through June 30, 1977 (or, if the State made no supplementary payments in the period July 1, 1976 through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).".

SEC. 148. There is appropriated \$25,000,000 for carrying out title XXVI of the Omnibus Budget Reconciliation Act of 1981, relating to low income home energy assistance, which is in addition to amounts otherwise available for such title XXVI under this joint resolution.

SEC. 149. (A) Notwithstanding the first sentence of section 103(e)(4) of title 23, United States Code, the Secretary of Transportation shall approve the withdrawal from the Interstate System the route of Interstate Route 95 and Interstate Route 695 from the intersection with Interstate Route 295 in Hopewell Township, Mercer County, New Jersey, to the proposed intersection with Interstate Route 287 in Franklin Township, Somerset County, New Jersey.

(B) Notwithstanding any other provision of law, the Secretary of Transportation is authorized and directed, pursuant to section 103 of such title, to designate as part of the Interstate Highway System the New Jersey Turnpike from exit 10 to the interchange with the Pennsylvania Turnpike and the Pennsylvania Turnpike from such interchange to and including the proposed interchange with Interstate Route 95 in Bucks County, Pennsylvania.

(C) The Secretary of Transportation is further authorized and directed to designate Interstate Route 95 and assure through proper sign designations the orderly connection of Interstate Route 95 pursuant to this section.

SEC. 150. Within 60 days of receipt of a complete abandoned mine reclamation fund grant application from any eligible State under the provisions of the Surface Mining Control and Reclamation Act (91 Stat. 460) the Secretary of Interior shall grant to such State any and all funds available for such purposes in the applicable appropriations Act.

SEC. 151. Notwithstanding Public Law 95-622, funds made available to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research under Public Law 97-216 shall remain available until March 31, 1983.

SEC. 152. Section 10526(a) of title 49, United States Code, is amended—

- (1) by striking "or" at the end of paragraph (12);
- (2) by striking the period at the end of paragraph (13), and inserting in lieu thereof " ; or, " ; and
- (3) by adding at the end thereof the following:
 "(14) transportation of broken, crushed, or powdered glass."

SEC. 153. None of the funds appropriated in this joint resolution or Public Law 97-276 shall be used for the development, initiation, or implementation of plans, drawings, architectural engineering work, design work, site preparation or acquisition for, or the construction of, any new Senate office buildings or additions to existing Senate office buildings. This provision does not apply to planning, construction, or completion for the Philip A. Hart Senate Office Building.

95 Stat. 893.
42 USC 8621.

23 USC 103.

30 USC 1235
note.

30 USC 1235.

42 USC 2689
note.

Ante, p. 180.

Ante, p. 1186.

SEC. 166. Notwithstanding any other provision of law, an additional amount of \$2,000,000 shall be available to the Secretary of Labor to enter into a contractual or other agreement to support social science and historical studies of international labor issues.

SEC. 167. Notwithstanding any other provision of this joint resolution, there is appropriated to the Department of the Interior \$3,000,000 for National Park Service Construction.

Approved December 21, 1982.

LEGISLATIVE HISTORY—H.J. Res. 631:

HOUSE REPORT: No. 97-959 (Comm. on Appropriations) and No. 97-980 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 128 (1982):

Dec. 14, considered and passed House.

Dec. 18, 19, considered and passed Senate, amended.

Dec. 19, House concurred in Senate amendments with amendments.

Dec. 20, Senate and House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 18, No. 51 (1982):

Dec. 21, Presidential statement.

FURTHER CONTINUING APPROPRIATIONS, 1983

DECEMBER 10, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. WHITTEN, on behalf of the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.J. Res. 631]

The Committee on Appropriations submits the following report in explanation of the accompanying House Joint Resolution 631, making further continuing appropriations until March 15, 1983, and providing for productive employment.

The Committee on Appropriations has reported twelve of the thirteen regular annual appropriation bills for fiscal year 1983. The House has passed eleven of the bills and additional action on remaining bills is expected during this session. The Committee has carefully reviewed the unique circumstances affecting the appropriations process and has analyzed the prospects for further progress during the balance of this year. To date, three annual appropriations bills for fiscal year 1983 have been enacted. It is hoped that conferences will be completed on several other bills during the balance of the second session of the 97th Congress. The Committee believes that program efficiency and effectiveness is improved when the uncertainty involved in most continuing appropriations is removed. For this reason, the accompanying joint resolution carries a termination date of March 15, 1983. It is hoped, of course, that additional regular bills will be enacted and thus disengage from the continuing resolution.

Major continuing resolutions (providing for nearly the entire government) have been required for the past four fiscal years. The Committee considers this to be a very undesirable situation from the standpoint of orderly and effective administration of federal programs. The Committee reaffirms its strong support for the principle of financing federal programs under the traditional authorization and appropriation process including individual appropriation bills. It will continue efforts to get regular annual bills signed into

No material pertaining to Social Security Act Amendments in this report.

MAKING FURTHER CONTINUING APPROPRIATIONS AND PROVIDING FOR
PRODUCTIVE EMPLOYMENT FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1983

DECEMBER 20 (legislative day of DECEMBER 19), 1982.—Ordered to be printed

Mr. WHITTEN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.J. Res. 631]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.J. Res. 631) making further continuing appropriations and providing for productive employment for the fiscal year ending September 30, 1983, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 6, 10, 11, 12, 16, 22, 33, 35, 37, 40, 41, 58, 61, 67, 73, 81, 82, 83, 84, 86, 87, 88, 90, 91, 97, 98, 109, 112, 113, 114, 115, 116, 120, 122, 123, 128, and 130.

That the House recede from its disagreement to the amendments of the Senate numbered 1, 2, 3, 4, 5, 15, 17, 18, 19, 20, 21, 24, 25, 27, 28, 29, 32, 36, 38, 39, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 59, 60, 62, 63, 64, 65, 66, 68, 69, 72, 74, 76, 77, 78, 80, 85, 89, 100, 101, 102, 103, 104, 105, 106, 107, 108, 111, 117, 118, 124, 126, 129, and 132, and agree to the same.

Amendment numbered 7:

That the House recede from its disagreement to the amendment of the Senate numbered 7, and agree to the same with an amendment, as follows:

In lieu of the matter stricken by said amendment insert the following: , *or any other provision of law or section 102 of this joint resolution*; and the Senate agree to the same.

Amendment numbered 8:

That the House recede from its disagreement to the amendment of the Senate numbered 8, and agree to the same with an amendment, as follows:

No material pertaining to Social Security Act Amendments
in this report.

Finder's Aid
P.L. 97-424 (96 Stat. 2097) Approved January 6, 1983
"Surface Transportation Assistance Act of 1982"
Title V "Highway Revenue Act of 1982"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-555</u>	<u>HCRep. 97-987</u>
AFDC--Home Energy Assistance Income Exclusion (Technical Amendment)	402(a)(34)	545(b)(1)	2198	--	--
AFDC--Home Energy Assistance Income Exclusion (Technical Amendment)	402(a)(35)	545(b)(2)	2198	--	--
AFDC--Home Energy Assistance Income Exclusion	402(a)(36) New	545(b)(3)	2198	--	208
SSI--Income Exclusion--Home Energy Assistance (Technical Amendment)	1612(b)(11)	545(a)(1)	2198	--	--
SSI--Income Exclusion--Home Energy Assistance (Technical Amendment)	1612(b)(12)	545(a)(2)	2198	--	--
SSI--Income Exclusion--Home Energy Assistance	1612(b)(13) New	545(a)(3)	2198	--	208

Public Law 97-424
97th Congress

An Act

To authorize appropriations for construction of certain highways in accordance with title 23, United States Code, for highway safety, for mass transportation in urban and rural areas, and for other purposes.

Jan. 6, 1983

[H.R. 6211]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Surface Transportation Assistance Act of 1982"

Surface
Transportation
Assistance Act of
1982.
23 USC 101 note.
Highway
Improvement
Act of 1982.

TITLE I

SHORT TITLE

SEC. 101. This title may be cited as the "Highway Improvement Act of 1982".

23 USC 101 note.

REVISION OF AUTHORIZATION FOR APPROPRIATIONS FOR THE
INTERSTATE SYSTEM

SEC. 102. Subsection (b) of section 108 of the Federal-Aid Highway Act of 1956, as amended, is amended by striking out "the additional sum of \$3,225,000,000 for the fiscal year ending September 30, 1984," and all that follows down through the period at the end of the sentence and by inserting in lieu thereof the following: "the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1984, the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1985, the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1986, the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1987, and the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1988, the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1989, and the additional sum of \$4,000,000,000 for the fiscal year ending September 30, 1990."

Ante, p. 1611.

MINIMUM APPORTIONMENT

SEC. 103. (a) For each of the fiscal years 1984, 1985, 1986, and 1987, no State, including the State of Alaska, shall receive less than one-half of 1 per centum of the total apportionment for the Interstate System under section 104(b)(5)(A) of title 23, United States Code. Whenever amounts made available under this subsection for the Interstate System in any State exceed the estimated cost of completing that State's portion of the Interstate System, and exceed the estimated cost of necessary resurfacing, restoration, rehabilitation, and reconstruction of the Interstate System within such State, the excess amount shall be eligible for expenditure for those purposes for which funds apportioned under paragraphs (1), (2), and (6) of such section 104(b) may be expended and shall also be available for expenditure to carry out section 152 of title 23, United States Code.

23 USC 101 note.

Ante, p. 1611.
23 USC 104 note.

(b) Section 4(b) of the Federal-Aid Highway Act of 1982 is repealed.

OBLIGATION CEILING

23 USC 104 note.

SEC. 104. (a) Notwithstanding any other provision of law, the total of all obligations for Federal-aid highways and highway safety construction programs shall not exceed—

- (1) \$12,100,000,000 for fiscal year 1983;
- (2) \$12,750,000,000 for fiscal year 1984;
- (3) \$13,550,000,000 for fiscal year 1985; and
- (4) \$14,450,000,000 for fiscal year 1986.

23 USC 144 note.
95 Stat. 1701.
95 Stat. 1672; 40
USC 818.

These limitations shall not apply to obligations for emergency relief under section 125 of title 23, United States Code, or projects covered under section 147 of the Surface Transportation Assistance Act of 1978, or section 9 of the Federal-Aid Highway Act of 1981 or section 118 of the National Visitor Center Facilities Act of 1968. No obligation constraints shall be placed upon any ongoing emergency project carried out under section 125 of title 23, United States Code, or section 147 of the Surface Transportation Assistance Act of 1978.

(b) For each of the fiscal years 1983, 1984, 1985, and 1986, the Secretary of Transportation shall distribute the limitation imposed by subsection (a) by allocation in the ratio which sums authorized to be appropriated for Federal-aid highways and highway safety construction which are apportioned or allocated to each State for such fiscal year bears to the total of the sums authorized to be appropriated for Federal-aid highways and highway safety construction which are apportioned or allocated to all the States for such fiscal year.

(c) During the period October 1 through December 31, 1982, no State shall obligate more than 35 per centum of the amount distributed to such State under subsection (b) for fiscal year 1983, and the total of all State obligations during such period shall not exceed 25 per centum of the total amount distributed to all States under such subsection for such fiscal year.

(d) Notwithstanding subsections (b) and (c), the Secretary shall—

(1) provide all States with authority sufficient to prevent lapses of sums authorized to be appropriated for Federal-aid highways and highway safety construction which have been apportioned or allocated to a State, except in those instances in which a State indicates its intention to lapse sums apportioned under section 104(b)(5)(A) of title 23, United States Code;

(2) after August 1 of each of the fiscal years 1983, 1984, 1985, and 1986, revise a distribution of the funds made available under subsection (b) for such fiscal year if a State will not obligate the amount distributed during such fiscal year and redistribute sufficient amounts to those States able to obligate amounts in addition to those previously distributed during such fiscal year giving priority to those States having large unobligated balances of funds apportioned under section 104 of title 23, United States Code, and giving priority to those States which, because of statutory changes made by this Act and the Federal-Aid Highway Act of 1981, have experienced substantial proportional reductions in their apportionments and allocations; and

(3) not distribute amounts authorized for administrative expenses and forest highways.

95 Stat. 1699.
23 USC 101 note.

Ante, p. 580.

(3) Section 3454(a)(2)(B) (relating to definitions of interest, dividend, and patronage dividends) is amended by striking out "law" and inserting in lieu thereof "this title".

Ante, p. 591.

(4) Section 6049(b)(2)(B) (relating to returns regarding payments of interest) is amended by striking out "law" and inserting in lieu thereof "this title".

26 USC 6362.

(5) Section 6362(b)(4)(A) (relating to qualified State individual income taxes) is amended by striking out "103(a)(1)" and inserting in lieu thereof "103(a)".

Approved January 6, 1983.

LEGISLATIVE HISTORY—H.R. 6211:

HOUSE REPORTS: No. 97-555 (Comm. on Public Works and Transportation) and No. 97-987 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 128 (1982):

Dec. 6, considered and passed House.

Dec. 10, 13-16, 19-21, considered and passed Senate, amended.

Dec. 21, House agreed to conference report.

Dec. 21, 23, Senate considered and agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 19, No. 1 (1983):
Jan. 6, Presidential statement.

SURFACE TRANSPORTATION ASSISTANCE ACT OF 1982

MAY 17, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HOWARD, from the Committee on Public Works and Transportation, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 6211]

[Including cost estimate and comparison of the Congressional Budget Office]

The Committee on Public Works and Transportation, to whom was referred the bill (H.R. 6211) to authorize appropriations for construction of certain highways in accordance with title 23, United States Code, for highway safety, for mass transportation in urban and rural areas, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

INTRODUCTION

The Surface Transportation Assistance Act of 1982 charts a new course for Federal policy governing highways and mass transit, greatly increasing emphasis on preservation, redevelopment, and selective expansion of the existing transportation infrastructure that remains critical to the economic well-being of the nation. The measure reported to the House by the Committee represents a response to demonstrated needs in terms of deterioration of physical facilities and capacity overwhelmed by demand, documented in more than a dozen hearings during the 97th Congress which elicit-

No material pertaining to Social Security Act Amendments
in this report.

SURFACE TRANSPORTATION ASSISTANCE ACT OF 1982

DECEMBER 21 (legislative day of DECEMBER 19), 1982.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 6211]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 6211) to authorize appropriations for construction of certain highways in accordance with title 23, United States Code, for highway safety, for mass transportation in urban and rural areas, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

That this Act may be cited as the "Surface Transportation Assistance Act of 1982".

TITLE I

SHORT TITLE

SEC. 101. This title may be cited as the "Highway Improvement Act of 1982".

REVISION OF AUTHORIZATION FOR APPROPRIATIONS FOR THE INTERSTATE SYSTEM

SEC. 102. Subsection (b) of section 108 of the Federal Aid Highway Act of 1956, as amended, is amended by striking out "the additional sum of \$3,225,000,000 for the fiscal year ending September 30, 1984," and all that follows down through the period at the end of

III. OTHER PROVISIONS

A. SOCIAL SECURITY ACT PROVISIONS: DISREGARD OF CERTAIN ENERGY ASSISTANCE IN SUPPLEMENTAL SECURITY INCOME (SSI) AND AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAMS

Present-law

In the welfare programs of SSI and AFDC, the monthly payment to each recipient is determined by subtracting that person's other income from a specified assistance standard. The AFDC and SSI statutes specify certain limited types of income which are not to be counted in making these determinations. Otherwise, all income serves to reduce the assistance payment. (In the case of SSI, in-kind income is explicitly included in the definition of income.)

House bill

No provision.

Senate amendment

The Senate amendment would add to the items which are not counted as income certain types of assistance provided to help AFDC and SSI recipients meet their energy needs. Any such assistance in cash or kind would be excluded from income if it is based on the need for assistance with home energy costs and is furnished by a home heating oil or gas supplier or by a utility company (including a municipal utility) which provides home energy. Assistance of this type provided by a non-profit organization would also be excluded from income but only if it is in-kind assistance. In the case of the AFDC program, the exclusion provided by the amendment would be optional with each State. The amendment would apply to assistance provided from the month after enactment through June 1985. Prior to April 1985, the Secretary of Health and Human Services would be required to report on the implementation of the amendment.

Conference agreement

The conference agreement follows the Senate amendment.

B. UNEMPLOYMENT COMPENSATION PROVISIONS: EXTENSION OF FEDERAL SUPPLEMENTAL COMPENSATION (FSC) BENEFITS

Present law

Most States provide up to a maximum of 26 weeks of State unemployment compensation benefits to unemployed individuals who meet the qualifying requirements of State law. Many claimants qualify for less than the maximum 26 weeks of State benefits. State benefits are financed out of State unemployment trust funds.

Under the permanent Federal-State extended benefits (EB) program, additional weeks of unemployment compensation are payable to individuals who exhaust their State benefits during periods of high unemployment. No one may receive more than 13 weeks of extended benefits, or more than 39 weeks of State plus extended benefits. Extended benefits are financed one-half out of State unemployment trust funds and one-half out of Federal unemployment trust funds.

Finder's Aid
P.L. 97-448 (96 Stat. 2365) Approved January 1, 1983
"Technical Corrections Act of 1982"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.*</u>
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	210(p)	309(a)(10)	2408
Medicare--Coverage of Federal Employees (Technical Amendment)	210(p) Redesignated as (q)	309(b)(23)	2410
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(a)(2)(A)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(a)(2)(B)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(a)(2)(C)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(b)(2)(B)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(b)(2)(C)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(g)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226(h)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	226A(a)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--End Stage Renal Disease (Technical Correction)	226A(a)(1)(B) (iii)	309(b)(1)	2408

* No material relating to Social Security Act Amendments contained in H. Rep. 97-794,
S. Rep. 97-592, and H. C. Rep. 97-986.

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>
Utilization and Quality Control Peer Review (Technical Correction-- Cross-Reference)	1153(d)(1)	309(b)(2)(A)	2408
Utilization and Quality Control Peer Review (Technical Correction-- Cross-Reference)	1153(d)(2)	309(b)(2)(B)	2408
Utilization and Quality Control Peer Review (Technical Correction-- Cross-Reference)	1154(a)(1)(A)	309(b)(3)	2408
Utilization and Quality Control Peer Review (Technical Correction-- Terminology)	1154(a)(2)(B)	309(b)(4)	2409
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	1811(1)	309(a)(10)	2408
Medicare--Coverage of Federal Employees--Effective Date (Technical Correction)	1811(2)	309(a)(10)	2408
Medicare--Scope of Benefits (Grammatical Correction)	1812(d)(2)(A)	309(b)(5)	2409
Medicare--Hospice Care (Grammatical Correction)	1814(i) Heading	309(b)(6)	2409
Medicare--Hospice Care (Grammatical Correction)	1814(i)(1)	309(b)(7)	2409
Medicare--Amounts of Premiums (Technical Correction)	1839(d)	309(b)(8)	2409
Medicare--Duplicate Payments for Outpatient Services (Grammatical Correction)	1842(b)(3)	309(a)(2)	2408
Medicare--Prohibiting Recomputation of Payments Under Certain Per- centage Arrangements (Citation Correction)	1861(v)(7)(C)	309(a)(4)	2408
Medicare--Hospice Care (Grammatical Correction)	1861(dd) Heading	309(b)(9)	2409
Medicare--Secondary to Employee Group Health Plans (Technical Correction)	1862(b)(3)(A)(1)	309(b)(10)(A)	2409

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>
Medicare--Secondary to Employee Group Health Plans (Technical Correction)	1862(b)(3)(A)(1)	309(b)(10)(B)	2409
Medicare--Agreements with Providers (Grammatical Correction)	1866(a)(2)(A)	309(b)(11)	2409
Medicare--Agreements with Providers (Cross-Reference Correction)	1866(b)(2)(A)	309(a)(5)	2408
Medicare--Health Maintenance Organization (Cross-Reference Correction)	1876(g)(1)	309(b)(12)	2409
Medicare--Payment for Inpatient Services (Grammatical Correction)	1886(a)(4)	309(b)(13)	2409
Medicare--Payment for Inpatient Services (Grammatical Correction)	1886(b)(1)	309(b)(14)	2409
Medicare--Payment for Inpatient Services (Technical Correction)	1886(b)(6)(C)	309(b)(15)	2409
Medicaid--Federal Percentage of Payments--Effective Date (Technical Correction)	1903(t)(3)	309(b)(16)	2409
Medicaid--Skilled Nursing or Intermediate Care Services (Technical Correction)	1915(c)(2)(B)	309(b)(17)	2409
Medicaid--Use of Fees and Charges (Technical Correction--Terminology)	1916(c)	309(b)(18)	2409
Medicaid--Use of Fees and Charges (Cross-Reference Correction)	1916(d)	309(b)(19)	2410
Medicaid--Use of Fees and Charges (Grammatical Correction)	1916(d)(5)	309(b)(20)	2410
Medicaid--Liens, Adjustments and Recoveries, Transfer of Assets (Technical Correction--Editorial)	1917(b)(2)(B)	309(b)(21)	2410
Medicaid--Liens, Adjustments and Recoveries, Transfer of Assets (Technical Correction--Editorial)	1917(c)(2)(B) (iii)(I)	309(b)(22)(A)	2410
Medicaid--Liens, Adjustments and Recoveries, Transfer of Assets (Grammatical Correction)	1917(c)(2)(B) (iii)(IV)	309(b)(22)(B)	2410

Public Law 97-448
97th Congress

An Act

To make technical corrections in the Economic Recovery Tax Act of 1981 and certain other recent tax legislation.

Jan. 12, 1983
[H.R. 6056]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1954 CODE.

(a) **SHORT TITLE.**—This Act may be cited as the “Technical Corrections Act of 1982”.

Technical
Corrections Act
of 1982.

26 USC 1 note.

(b) **AMENDMENT OF 1954 CODE.**—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954.

26 USC 1 *et seq.*

TITLE I—AMENDMENTS RELATED TO ECONOMIC RECOVERY TAX ACT OF 1981

SEC. 101. AMENDMENTS RELATED TO TITLE I OF THE ACT.

(a) **AMENDMENTS RELATED TO SECTION 101.**—

95 Stat. 176.

(1) **EFFECTIVE DATE FOR AMENDMENT TO SECTION 21.**—Paragraph (1) of section 101(f) of the Economic Recovery Tax Act of 1981 (relating to effective dates for rate cuts) is amended by inserting before the period at the end thereof the following: “; except that the amendment made by paragraph (3) of subsection (d) shall apply to taxable years ending after December 31, 1981”.

95 Stat. 184.
26 USC 1 note.

(2) **RATE REDUCTION TAX CREDIT.**—Section 6428 (relating to 1981 rate reduction tax credit) is amended by adding at the end thereof the following new subsection:

26 USC 6428.

“(d) **SPECIAL RULES.**—For purposes of this section—

“(1) **INDIVIDUALS TO WHOM 50 PERCENT MAXIMUM RATE OR 20 PERCENT CAPITAL GAIN RATE APPLIES.**—

“(A) **IN GENERAL.**—In the case of any individual to whom this paragraph applies, in determining the amount of the credit allowable under subsection (a)—

“(i) the portion of the tax imposed by section 1 determined under section 1348(a)(2) (as in effect before its repeal by the Economic Recovery Tax Act of 1981), and

“(ii) the portion of the tax imposed by section 1 determined under subsection (a)(2)(B) of section 102 of the Economic Recovery Tax Act of 1981,

shall not be taken into account.

95 Stat. 186.
26 USC 1201
note.

“(B) **INDIVIDUALS TO WHOM PARAGRAPH APPLIES.**—This paragraph applies to any individual if the tax imposed by section 1 for the taxable year is determined under—

“(i) section 1348 (as in effect before its repeal by the Economic Recovery Tax Act of 1981), or

SEC. 309. TECHNICAL CORRECTIONS RELATING TO SPENDING REDUCTION PROVISIONS OF TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982.

Ante, p. 324.

42 USC 1395ww
note.

42 USC 1395u
note.

42 USC 1395xx
note.

42 USC 1395x.

42 USC 1395cc.

42 USC 1395b-1
note, 1395f note.

42 USC 1395f
note.

42 USC 1396a,
1396o.

42 USC 1320c
note.

42 USC 426 note.

Ante, p. 282.

42 USC 1320c-2.

42 USC 1320c-3.

(a)(1) Section 101(b)(2)(B) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended by striking out "title 5" and inserting in lieu thereof "title 44".

(2) Section 104(b) of such Act is amended by striking out "made by this section".

(3) Section 108 of such Act is amended by redesignating subsection (c) as subsection (b).

(4) Section 109(b)(2) of such Act is amended by striking out "section 108(b)(2)" and inserting in lieu thereof "section 108(a)(2)".

(5) Section 122(g)(5) of such Act is amended by striking out "1866(b)(2)(A)" and inserting in lieu thereof "1866(a)(2)(A)".

(6) Section 122 of such Act is amended by redesignating the last three subsections as subsections (i), (j), and (k).

(7) Section 122(k) of such Act (as redesignated by paragraph (6)) is amended by striking out "1861(dd)(2)(A)(iv)" and inserting in lieu thereof "1861(dd)(2)(A)(iii)".

(8) Section 131 of such Act is amended by redesignating the last two subsections thereof as subsections (c) and (d).

(9)(A) The second sentence of section 150(a) of such Act and the first sentence of section 150(b) of such Act are each amended by striking out "contract" and inserting in lieu thereof "agreement".

(B) The first sentence of section 150(b) of such Act is amended by striking out "contracts" and inserting in lieu thereof "agreements".

(10) Section 278(c)(2)(A) of such Act is amended by striking out "paragraph (3) of that subsection" and inserting in lieu thereof "paragraph (2) of that subsection".

(11) Section 278(d) of such Act is amended—

(A) by amending paragraph (1) to read as follows:

"(1) **IN GENERAL.**—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs service both during January 1983, and before January 1, 1983, which constitutes medicare qualified Federal employment (as defined in section 210(p) of such Act), the individual's medicare qualified Federal employment (as so defined) performed before January 1, 1983, for which remuneration was paid before such date, shall be considered to be 'employment' (as defined for purposes of title II of such Act), but only for the purpose of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act.";

(B) by striking out paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2) and striking out "or (2)" in subparagraph (A) thereof.

(b)(1) Section 226A(a)(1)(B)(iii) of the Social Security Act is amended by striking out "210(p)" after December 31, 1982," and inserting in lieu thereof "section 210(p)".

(2) Section 1153(d) of such Act is amended—

(A) in paragraph (1), by striking out "(c)(5)(B)" and inserting in lieu thereof "(c)(6)(B)"; and

(B) in paragraph (2), by striking out "(c)(5)(C)" and inserting in lieu thereof "(c)(6)(B)".

(3) Section 1154(a)(1)(A) of such Act is amended by striking out "or otherwise allowable under section 1862(a)(1)" and inserting in lieu

thereof “and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1862”.

(4) Section 1154(a)(2)(B) of such Act is amended by striking out “posthospital”. 42 USC 1320c-3.

(5) Section 1812(d)(2)(A) of such Act is amended by striking out “or to other than services” and inserting in lieu thereof “or to services”. 42 USC 1395d.

(6) The heading of subsection (i) of section 1814 of such Act is amended to read as follows:

“Payment for Hospice Care”.

(7) Section 1814(i)(1) of such Act is amended by inserting “made” before “for bereavement counseling”. 42 USC 1395f.

(8) Section 1839(d) of such Act is amended by striking out “subsection (b) or (c)” and inserting in lieu thereof “subsection (b), (c), or (g)”. 42 USC 1395r.

(9) The heading of subsection (dd) of section 1861 of such Act is amended to read as follows:

“Hospice Care; Hospice Program”.

(10) Section 1862(b)(3)(A)(i) of such Act is amended— 42 USC 1395y.

(A) by inserting “in any month” after “service furnished”; and

(B) by inserting “during any part of such month” after “70 years of age” each place it appears.

(11) Section 1866(a)(2)(A) of such Act is amended by inserting a comma after “1813(a)(1)”. 42 USC 1395cc.

(12) Section 1876(g)(1) of such Act is amended by striking out “subsection (b)(1)” and inserting in lieu thereof “subsection (b)”. 42 USC 1395mm.

(13) Section 1886(a)(4) of such Act is amended by striking out “and such costs are determined” and inserting in lieu thereof “as such costs are determined”. 42 USC 1395ww.

(14) Section 1886(b)(1) of such Act is amended by striking out “sections 1814(b)” and inserting in lieu thereof “section 1814(b)”. 42 USC 1395ww.

(15) Section 1886(b)(6)(C) of such Act is amended by striking out “under this subsection” in the matter before clause (i) and inserting in lieu thereof “under this title (taking into account any limitation under subsection (a))”.

(16) Section 1903(t)(3) of such Act is amended to read as follows: 42 USC 1396b.

“(3) Only for the purposes of computing under this subsection the Federal share of expenditures for a State for fiscal years 1982, 1983, and 1984 (in the case of the payment which may be made for the first quarter of fiscal years 1983, 1984, and 1985, respectively), the Federal medical assistance percentage for fiscal years 1982, 1983, and 1984 shall be the lower of the Federal medical assistance percentage for the State in effect for fiscal year 1981, or the Federal medical assistance percentage for the State in effect for fiscal year 1982.”.

(17) Section 1915(c)(2)(B) of such Act is amended by striking out “need for such services” in the matter following clause (iii) and inserting in lieu thereof “need for such skilled nursing facility or intermediate care facility services”. 42 USC 1396n.

(18) Section 1916(c) of such Act is amended by striking out “this subparagraph” and inserting in lieu thereof “this subsection”. 42 USC 1396o.

42 USC 1396o.

(19) Section 1916(d) of such Act is amended by striking out “unless authorized under this section” and inserting in lieu thereof “, except as provided in subsections (a)(3) and (b)(3)”.

42 USC 1396p.

(20) Section 1916(d)(5) of such Act is amended by striking out “in which participation is voluntary, or in which provision is made” and inserting in lieu thereof “is voluntary, or makes provision”.

(21) Section 1917(b)(2)(B) of such Act is amended by striking out “and has lawfully resided” and inserting in lieu thereof “who has lawfully resided”.

(22) Section 1917(c)(2)(B)(iii) of such Act is amended—

(A) in subclause (I), by striking out “cannot” and inserting in lieu thereof “can”; and

(B) in subclause (IV), by striking out “if”.

Ante, p. 551.

42 USC 410.

(23) Subsection (p) of section 210 of such Act (as added by section 269(b) of the Tax Equity and Fiscal Responsibility Act of 1982, relating to treatment of real estate agents) is redesignated as subsection (q).

42 USC 426 note.

(c)(1) Any amendment to the Tax Equity and Fiscal Responsibility Act of 1982 made by this section shall be effective as if it had been originally included in the provision of such Act to which such amendment relates.

42 USC 426-1
note.

(2) Any amendment to the Social Security Act made by this section shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of such Act was amended or added by the Tax Equity and Fiscal Responsibility Act of 1982.

42 USC 1320c
note.

(d) In order to avoid unfairly discriminating against professional standards review organizations whose performance was evaluated during the first and second calendar quarters of 1982, the Secretary of Health and Human Services shall disregard the results of such evaluations and shall carry out such new evaluations of such organizations as may be necessary to select utilization and quality control peer review organizations in accordance with subtitle C of title I of the Tax Equity and Fiscal Responsibility Act of 1982 and part B of title XI of the Social Security Act as amended by such subtitle.

42 USC 1395b-1
note.

(e) Section 122(i) of the Tax Equity and Fiscal Responsibility Act of 1982 (as redesignated by subsection (a)(6) of this section) is amended by adding at the end thereof the following new paragraph:

“(3)(A) Notwithstanding the provisions of paragraph (1), the Secretary of Health and Human Services, upon request of the hospice involved, shall permit continuation of a hospice demonstration project described in paragraph (1) until September 30, 1986, if the hospice involved in such demonstration project does not provide hospice care directly but acts as a channeling agency for the provision of hospice care.

“(B) During the period after the date on which a hospice demonstration project described in subparagraph (A) would otherwise have terminated under the provisions of paragraph (1), and prior to September 30, 1986, any such hospice demonstration project shall be subject to the same requirements as are imposed under the hospice program provided for under the amendments made by this section with respect to reimbursement and benefits, other than the requirement that certain benefits be provided directly by the hospice involved.”.

SEC. 310. TECHNICAL CORRECTION RELATING TO FEDERAL SUPPLEMENTAL UNEMPLOYMENT COMPENSATION PROGRAM.

(a) Section 602(d) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended—

26 USC 3304
note.

(1) by striking out “and” at the end of paragraph (1);

(2) by striking out the period at the end of paragraph (2) and inserting in lieu thereof “; and”; and

(3) by inserting after paragraph (2) the following new paragraph:

“(3) the maximum amount of Federal supplemental compensation payable to any individual for whom an account is established under subsection (e) shall not exceed the lesser of (A) the amount established in such account for such individual, or (B) in the case of an individual filing a claim under the interstate benefit payment plan for Federal supplemental compensation, an amount equal to his average weekly benefit amount (as determined for purposes of section 202(b)(1)(C) of the Federal-State Extended Unemployment Compensation Act of 1970) for his benefit year, multiplied by the number ‘6’, ‘8’, or ‘10’, whichever is applicable under subsection (e)(2)(A)(ii) in the State in which such individual is filing such interstate claim under the interstate benefit payment plan for the week in which he is filing such claim.”.

(b) The amendment made by subsection (a) shall be effective as if it had been originally included in section 602 of the Tax Equity and Fiscal Responsibility Act of 1982.

Effective date.
26 USC 3304
note.
Ante, p. 702.

SEC. 311. EFFECTIVE DATES.

(a) **FOR SECTIONS 301, 302, AND 303.**—The amendments made by sections 301, 302, and 303 shall apply to dispositions made after October 19, 1980, in taxable years ending after such date.

26 USC 453 note.

(b) **FOR SECTION 304.**—

(1) The amendment made by subsection (a) of section 304 shall take effect as if included in the amendments made by section 3 of the Bankruptcy Tax Act of 1980.

26 USC 443 note.

(2) The amendment made by subsection (b) of section 304 shall take effect as if included in the amendments made by section 4 of such Act.

94 Stat. 3397.

26 USC 368 note.

94 Stat. 3401.

(c) **FOR SECTION 305.**—

(1) The amendment made by subsection (a) of section 305 shall take effect on December 28, 1980.

26 USC 404A
note.

(2) The amendments made by subsection (b) of section 305 shall take effect on October 14, 1980.

26 USC 194A
note.

(3) The amendment made by subsection (c) of section 305 shall take effect as if included in the amendments made by section 421 of the Revenue Act of 1978.

26 USC 55 note.

(4) The amendments made by subsection (d) of section 305 shall take effect on the date of the enactment of the Subchapter S Revision Act of 1982.

26 USC 221 note.

26 USC 7448
note.

Ante, p. 1726.

26 USC 31 note.

Ante, p. 324.

(5) The amendment made by subsection (e) of section 305 shall take effect on the date of the enactment of the Miscellaneous Revenue Act of 1982.

(d) FOR SECTION 306.—The amendments made by section 306 shall take effect as if included in the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 to which such amendments relate.

Approved January 12, 1983.

LEGISLATIVE HISTORY—H.R. 6056:

HOUSE REPORTS: No. 97-794 (Comm. on Ways and Means) and No. 97-986 (Comm. of Conference).

SENATE REPORT No. 97-592 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 128 (1982):

Sept. 14, considered and passed House.

Sept. 30, considered and passed Senate, amended.

Dec. 13, House concurred in certain Senate amendments in others with amendments.

Dec. 21, House agreed to conference report.

Dec. 22, Senate agreed to conference report.



97TH CONGRESS }
2d Session

HOUSE OF REPRESENTATIVES

{ REPORT
No. 97-794

TECHNICAL CORRECTIONS ACT OF 1982

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 6056

[Including cost estimate of the Congressional Budget Office]



SEPTEMBER 8, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1982

No material relating to Social Security Act Amendments contained in this report.

TECHNICAL CORRECTIONS ACT OF 1982

SEPTEMBER 27 (legislative day, September 8), 1982.—Ordered to be printed

Mr. DOLE, from the Committee on Finance,
submitted the following

R E P O R T

[To accompany H.R. 6056]

The Committee on Finance, to which was referred the bill (H.R. 6056) to make technical corrections related to the Economic Recovery Tax Act of 1981, the Crude Oil Windfall Profit Tax Act of 1980, and the Installment Sales Revision Act of 1980, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments are shown in the reported bill, with the matter proposed to be stricken in linetype and the matter proposed to be inserted shown in italic type.

I. SUMMARY

In general, the bill contains technical, clerical, conforming, and clarifying amendments to provisions enacted by the Economic Recovery Tax Act of 1981 and certain other tax legislation. These amendments were developed as a result of a review of the application of the statutory changes made by such legislation, taking into account comments submitted to the committee from the Treasury Department, the Internal Revenue Service, the staff, and tax practitioners, and others from the public. The committee approved several amendments on September 24, 1982, as a result of the comments received.

The bill is divided into three general titles. The first title covers amendments to the Economic Recovery Tax Act of 1981. The second title covers amendments to the Crude Oil Windfall Profit Tax Act of 1980, and the third title covers amendments to the In-

No material relating to Social Security Act Amendments
contained in this report.

TECHNICAL CORRECTIONS ACT OF 1982

DECEMBER 21 (legislative day of DECEMBER 19), 1982.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 67057]

The committee of conference on the disagreeing votes of the two Houses on the Senate amendments numbered 9, 15, 18, 24, and 27 to the bill (H.R. 6056) to make technical corrections related to the Economic Recovery Tax Act of 1981, the Crude Oil Windfall Profit Tax Act of 1980, and the Installment Sales Revision Act of 1980, and on the disagreeing votes of the two Houses on the House amendments to the Senate amendments numbered 1, 10, 14, 16, 17, 26, 30, 31, 33, 34, 36, and 37 to such bill, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 9 and 15.

That the House recede from its disagreement to the amendments of the Senate numbered 24 and 27; and agree to the same.

That the Senate recede from its disagreement to the House amendments to the Senate amendments numbered 1, 10, 14, 17, 26, 33, 34, 36, and 37; and agree to the same.

That the Senate recede from its disagreement to the House amendment to the Senate amendment numbered 16 and agree to the same with an amendment as follows:

In lieu of striking out the matter proposed to be stricken out by the House amendment, strike out line 24 on page 7 of the Senate amendments and all that follows down through line 23 on page 8 of the Senate amendments and, in lieu of inserting the matter proposed to be inserted by the House amendment, insert the following:

(ii) *ELECTION BY TAXPAYER OF RETROACTIVE APPLICATION.*—

(I) *RETROACTIVE APPLICATION.*—*If the taxpayer so elects, the amendments made by subparagraphs (B) and (C) shall apply as if included within the amendments made by title V of the Economic Recovery Tax Act of 1981.*

No material relating to Social Security Act Amendments contained in this report.

Finder's Aid
P.L. 97-455 (96 Stat. 2497) Approved January 12, 1983
"Temporary Payment of Disability Benefits and Other Matters"

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-833</u>	<u>S.Rep. 97-648</u>	<u>HCRep. 97-985</u>
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(b)(2)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(b)(4)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits (Technical Amendment)	202(b)(4)(A)	7(c)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(c)(1)(B)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(c)(1)(C)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(c)(2)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits (Technical Amendment)	202(c)(2)(A)	7(c)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(c)(3)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(e)(2)(A)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits (Technical Amendment)	202(e)(8)(A)	7(c)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(e)(8)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(1)(D)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(1)(E)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(1)(F)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits (Technical Amendment)	202(f)(2)(A)	7(c)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(2)	7(a)(1)	2501	--	--	12

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>96 Stat.</u>	<u>H.Rep. 97-833</u>	<u>S.Rep. 97-648</u>	<u>HCRep. 97-985</u>
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(3)(A)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(f)(7)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(g)(2)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits (Technical Amendment)	202(g)(4)(A)	7(c)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(g)(4)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(p)(1)	7(a)(1)	2501	--	--	12
Public Pension Offset Against Dependent Spouses' Benefits-- Effective Date	202(s)(3)	7(a)(1)	2501	--	--	12
Evidentiary Hearings In Reconsideration of Disability Benefit Terminations (Technical Amendment)	205(b) Redesignated as (b)(1)	4(a)(1)	2499	--	--	--
Evidentiary Hearings In Reconsideration of Disability Benefit Terminations	205(b)(2) New	4(a)(2)	2499	--	--	12
Periodic Review of Disability Cases (Technical Amendment)	221(i) Redesignated as (i)(1)	3(1)	2499	--	--	--
Periodic Review of Disability Cases (Technical Amendment)	221(i)(1)	3(2)	2499	--	--	--
Waiver of Periodic Review of Disability Cases	221(i)(2) New	3(3)	2499	--	2, 7, 11, 13	10
Periodic Review of Disability Cases--Report by Secretary	221(i)(3) New	6	2500	--	2, 9, 11, 13	11
Continued Payment of Disability Benefits During Appeal	223(g) New	2	2498	--	2, 6, 11, 13	10
Pension Offset Against Dependent Spouses' Benefits-- Entitlement to Hospital Insurance Benefits--Widow's Benefits--Effective Date	226(h)(1)(B)	7(a)(1)	2501	--	--	12

Public Law 97-455
97th Congress

An Act

To amend the Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Virgin Islands source income, to amend the Social Security Act to provide for a temporary period that payment of disability benefits may continue through the hearing stage of the appeals process, and for other purposes.

Jan. 12, 1983
[H.R. 7093]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. INCOME TAX RATE ON VIRGIN ISLANDS SOURCE INCOME.

(a) **IN GENERAL.**—Subpart D of part III of subchapter N of chapter 1 of the Internal Revenue Code of 1954 (relating to possessions) is amended by inserting after section 934 the following new section:

Internal
Revenue Code of
1954 and Social
Security Act,
amendments.

“SEC. 934A. INCOME TAX RATE ON VIRGIN ISLANDS SOURCE INCOME.

26 USC 934A.

“(a) **GENERAL RULE.**—For purposes of determining the tax liability incurred by citizens and resident alien individuals of the United States, and corporations organized in the United States, to the Virgin Islands pursuant to this title with respect to amounts received from sources within the Virgin Islands—

“(1) the taxes imposed by sections 871(a)(1) and 881 (as made applicable to the Virgin Islands) shall apply except that ‘10 percent’ shall be substituted for ‘30 percent’, and

“(2) subsection (a) of section 934 shall not apply to such taxes.

“(b) **SUBSECTION (a) RATES NOT TO APPLY TO PRE-EFFECTIVE DATE EARNINGS.**—

“(1) **IN GENERAL.**—Any change under subsection (a)(1), and any reduction under section 934 pursuant to subsection (a)(2), in a rate of tax imposed by section 871(a)(1) or 881 shall not apply to dividends paid out of earnings and profits accumulated for taxable years beginning before the effective date of the change or reduction.

“(2) **ORDERING RULE.**—For purposes of paragraph (1), dividends shall be treated as first being paid out of earnings and profits accumulated for taxable years beginning before the effective date of the change or reduction (to the extent thereof).”

(b) **WITHHOLDING.**—Subchapter A of chapter 3 of such Code (relating to withholding of tax on nonresident aliens and foreign corporations) is amended by adding at the end thereof the following new section:

“SEC. 1444. WITHHOLDING ON VIRGIN ISLANDS SOURCE INCOME.

26 USC 1444.

“For purposes of determining the withholding tax liability incurred in the Virgin Islands pursuant to this title (as made applicable to the Virgin Islands) with respect to amounts received from sources within the Virgin Islands by citizens and resident alien individuals of the United States, and corporations organized in the United States, the rate of withholding tax under sections 1441 and 1442 on income subject to tax under section 871(a)(1) or 881 (as

modified by section 934A) shall not exceed the rate of tax on such income under section 871(a)(1) or 881, as the case may be."

26 USC 934.

(c) **TECHNICAL AMENDMENT.**—Subsection (a) of section 934 of such Code is amended by inserting before the period at the end thereof "or in section 934A".

(d) **CLERICAL AMENDMENTS.**—

(1) The table of sections for subpart D of part III of subchapter N of chapter 1 of such Code is amended by inserting after the item relating to section 934 the following new item:

"Sec. 934A. Income tax rate on Virgin Islands source income."

(2) The table of sections for subchapter A of chapter 3 of such Code is amended by adding at the end thereof the following new item:

"Sec. 1444. Withholding on Virgin Islands source income."

26 USC 934A
note.

(e) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to amounts received after the date of the enactment of this Act in taxable years ending after such date.

(2) **WITHHOLDING.**—The amendment made by subsection (b) shall apply to payments made after the date of the enactment of this Act.

SEC. 2. CONTINUED PAYMENT OF DISABILITY BENEFITS DURING APPEAL.

42 USC 423.

Section 223 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Continued Payment of Disability Benefits During Appeal

"(g)(1) In any case where—

"(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

"(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

42 USC 421.

"(C) a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits, and the payment of any other benefits under this Act based on such individual's wages and self-employment income (including benefits under title XVIII), continued for an additional period beginning with the first month beginning after the date of the enactment of this subsection for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, (ii) the month preceding the month in which no such request for a hearing or an administrative review is pending, or (iii) June 1984.

42 USC 1395.

Overpayments.

"(2)(A) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1), and the final decision of the Secretary affirms the determination that he is

not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in subparagraph (B).

“(B) If the Secretary determines that the individual’s appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual’s election under paragraph (1) shall be subject to waiver consideration under the provisions of section 204.

Waiver
consideration.

42 USC 404.

“(3) The provisions of paragraphs (1) and (2) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made—

“(A) on or after the date of the enactment of this subsection, or prior to such date but only on the basis of a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, and

42 USC 421.

“(B) prior to October 1, 1983.”.

SEC. 3. PERIODIC REVIEWS OF DISABILITY CASES.

Section 221(i) of the Social Security Act is amended—

42 USC 421.

(1) by inserting “(1)” after “(i)”;

(2) by inserting “, subject to paragraph (2)” after “at least every 3 years”; and

(3) by adding at the end thereof the following new paragraph:

“(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Secretary determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed. The Secretary shall determine the appropriate number of cases to be reviewed in each State after consultation with the State agency performing such reviews, based upon the backlog of pending reviews, the projected number of new applications for disability insurance benefits, and the current and projected staffing levels of the State agency, but the Secretary shall provide for a waiver of such requirement only in the case of a State which makes a good faith effort to meet proper staffing requirements for the State agency and to process case reviews in a timely fashion. The Secretary shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the determinations made by the Secretary under the preceding sentence.”.

Case number
determination,
waiver.

Report to
congressional
committees.

(b) The amendments made by subsection (a) shall become effective on the date of the enactment of this Act.

Effective date.
42 USC 421 note.

SEC. 4. EVIDENTIARY HEARINGS IN RECONSIDERATIONS OF DISABILITY BENEFIT TERMINATIONS.

(a) IN GENERAL.—Section 205(b) of the Social Security Act is amended—

42 USC 405.

(1) by inserting “(1)” after “(b)”;

(2) by adding at the end thereof the following new paragraph:

“(2) In any case where—

“(A) an individual is a recipient of disability insurance benefits, or of child’s, widow’s, or widower’s insurance benefits based on disability,

“(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

“(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Secretary not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Secretary (before any hearing under paragraph (1) on the issue of such entitlement) of his determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Secretary where the finding was originally made by the State agency, and shall be made by the Secretary where the finding was originally made by the Secretary. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Secretary of a finding described in subparagraph (B) which was originally made by the Secretary, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).”.

42 USC 405 note.

Ante, p. 2499.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to reconsiderations (of findings described in section 205(b)(2)(B) of the Social Security Act) which are requested on or after such date as the Secretary of Health and Human Services may specify, but in any event not later than January 1, 1984.

42 USC 405 note.

SEC. 5. CONDUCT OF FACE-TO-FACE RECONSIDERATIONS IN DISABILITY CASES.

The Secretary of Health and Human Services shall take such steps as may be necessary or appropriate to assure public understanding of the importance the Congress attaches to the face-to-face reconsiderations provided for in section 205(b)(2) of the Social Security Act (as added by section 4 of this Act). For this purpose the Secretary shall—

(1) provide for the establishment and implementation of procedures for the conduct of such reconsiderations in a manner which assures that beneficiaries will receive reasonable notice and information with respect to the time and place of reconsideration and the opportunities afforded to introduce evidence and be represented by counsel; and

(2) advise beneficiaries who request or are entitled to request such reconsiderations of the procedures so established, of their opportunities to introduce evidence and be represented by counsel at such reconsiderations, and of the importance of submitting all evidence that relates to the question before the Secretary or the State agency at such reconsiderations.

SEC. 6. REPORT BY SECRETARY.

Ante, p. 2499.

Section 221(i) of the Social Security Act (as amended by section 3 of this Act) is further amended by adding at the end thereof the following new paragraph:

“(3) The Secretary shall report semiannually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the number of reviews of

continuing disability carried out under paragraph (1), the number of such reviews which result in an initial termination of benefits, the number of requests for reconsideration of such initial termination or for a hearing with respect to such termination under subsection (d), or both, and the number of such initial terminations which are overturned as the result of a reconsideration or hearing.”.

SEC. 7. OFFSET AGAINST SPOUSES' BENEFITS ON ACCOUNT OF PUBLIC PENSIONS.

(a) ADDITIONAL EXEMPTION.—

(1) Section 334 of the Social Security Amendments of 1977 (Public Law 95-216) is amended by adding at the end thereof the following new subsection:

42 USC 402 note.

“(h) In addition, the amendments made by the preceding provisions of this section shall not apply with respect to any monthly insurance benefit payable, under subsection (b), (c), (e), (f), or (g) (as the case may be) of section 202 of the Social Security Act, to an individual—

42 USC 402.

“(1) to whom there is payable for any month prior to July 1983 (or who is eligible in any such month for) a monthly periodic benefit (within the meaning of such provisions) based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2) of the Social Security Act); and

42 USC 418.

“(2) who at the time of application for or initial entitlement to such monthly insurance benefit under such subsection (b), (c), (e), (f), or (g)—

“(A) meets the dependency test of one-half support set forth in paragraph (1)(C) of such subsection (c) as it read prior to the enactment of the amendments made by this section, or an equivalent dependency test (if the individual is a woman), in the case of an individual applying for or becoming entitled to benefits under such subsection (b) or (c), or

“(B) meets the dependency test of one-half support set forth in paragraph (1)(D) of such subsection (f) as it read prior to the enactment of the amendments made by this section, or an equivalent dependency test (if the individual is a woman), in the case of an individual applying for or becoming entitled to benefits under such subsection (e), (f), or (g).”.

(2) Section 334(f) of such Act is amended by striking out “The amendments” and inserting in lieu thereof “Subject to subsections (g) and (h), the amendments”.

42 USC 402 note.

(b) **REPORT BY SECRETARY.**—The Secretary of Health and Human Services shall conduct a study of the provisions of title II of the Social Security Act which require an offset against spouses' and surviving spouses' benefits on account of public pensions, as added by section 334 of the Social Security Amendments of 1977 (taking into account the amendment made by subsection (a) of this section as well as the provisions of such section 334), and shall report to the Congress, no later than May 15, 1983, his recommendations for any permanent legislative changes in such provisions (or in the applicability of such provisions) which he may consider appropriate.

Study.

42 USC 401.

91 Stat. 1544.

(c) **TECHNICAL AMENDMENTS.**—Subsections (b)(4)(A), (c)(2)(A), (e)(8)(A), (f)(2)(A) and (g)(4)(A) of section 202 of the Social Security Act

42 USC 402.

are each amended by inserting “for purposes of this title” after “as defined in section 210”.

42 USC 402 note.

(d) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (c) of this section shall be effective with respect to monthly insurance benefits for months after November 1982.

Approved January 12, 1983.

LEGISLATIVE HISTORY—H.R. 7093:

HOUSE REPORTS: No. 97-833 (Comm. on Ways and Means) and No. 97-985 (Comm. of Conference).

SENATE REPORT No. 97-648 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 128 (1982):

Sept. 20, considered and passed House.

Dec. 3, considered and passed Senate, amended.

Dec. 14, House concurred in Senate amendment, in another with an amendment, and disagreed to certain amendments.

Dec. 21, Senate and House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 19, No. 2 (1983):
Jan. 12, Presidential statement.

REDUCTION IN RATE OF CERTAIN TAXES PAID TO VIRGIN ISLANDS

SEPTEMBER 16, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed.

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 7093]

The Committee on Ways and Means to whom was referred the bill (H.R. 7093) to amend the Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Virgin Islands source income, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. SUMMARY

The Treasury and the Government of the Virgin Islands take the position that present law imposes a 30-percent tax on the non-Virgin Islands recipient of certain Virgin Islands source passive investment income, and that present law also imposes withholding at the source by the V.I. payor of such income. The bill will reduce this tax to 10 percent when the recipient is a U.S. individual or corporation and impose a corresponding withholding obligation on the V.I. payor of such income. The bill will allow the V.I. Government further to reduce this 10-percent rate in its discretion. The bill will not affect payments of V.I. source passive income to non-U.S. persons.

II. EXPLANATION OF THE BILL

Present Law

Virgin Islands taxation in general

Under the Revised Organic Act, in the Virgin Islands, the U.S. Internal Revenue Code is generally applied as the local territorial

No material relating to Social Security Act Amendments in this report.

RATE OF CERTAIN TAXES PAID TO
VIRGIN ISLANDS

OCTOBER 1 (legislative day, SEPTEMBER 8), 1982.—Ordered to be printed

Mr. DOLE, from the Committee on Finance,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 7093]

[Including Cost Estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (H.R. 7093) to amend the Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Virgin Islands source income, having considered the same, reports favorably thereon with an amendment to the text and an amendment to the title and recommends that the bill as amended do pass.

The amendment to the text is shown in *italic* in the reported bill.

I. SUMMARY

Virgin Islands Taxes

The Treasury and the Government of the Virgin Islands take the position that present law imposes a 30-percent tax on the non-Virgin Islands recipient of certain Virgin Islands source passive investment income, and that present law also imposes withholding at the source by the V.I. payor of such income. The bill will reduce this tax to 10 percent when the recipient is a U.S. citizen, resident alien, or corporation and imposes a corresponding withholding obligation on the V.I. payor of such income. The bill will allow the V.I. Government further to reduce this 10-percent rate in its discretion. The bill will not affect payments of V.I. source passive income to non-U.S. persons.

Social Security Disability Insurance (DI)

In addition, the bill will make several changes in the social security disability insurance program relating to the continuing disability investigation (CDI) process. The bill will continue DI benefits and Medicare coverage, for certain terminated beneficiaries pursuing an appeal, through the Administrative Law Judge (ALJ) hearing; allow the Secretary to slow the CDI process; requires the Secretary to obtain medical evidence available for the 12-month period preceding the CDI review; and require the Secretary to report semiannually on various aspects of the CDI process.

II. EXPLANATION OF THE BILL

A. Rate of Certain Taxes Paid to Virgin Islands (sec. 1 of the bill and new secs. 934A and 1444 of the Code)

Present Law

Virgin Islands taxation in general

Under the Revised Organic Act of 1954, the U.S. Internal Revenue Code is generally applied in the Virgin Islands as the local territorial tax law, except that tax proceeds are paid into the treasury of the Virgin Islands. This system has been interpreted to require that, in applying the Internal Revenue Code in the Virgin Islands, the name "Virgin Islands" is substituted, where appropriate, for the name "United States" where it appears in the U.S. Code (the so-called "mirror image" system).

Corporate and individual "inhabitants" of the Virgin Islands are taxed on their worldwide income by the Virgin Islands and, by paying such tax to the Virgin Islands, are relieved of any income tax liability to the Federal Treasury, even on their U.S.-source income. All corporations chartered in the Virgin Islands are considered to be inhabitants of the Virgin Islands. In certain circumstances, a United States corporation may also qualify as an inhabitant of the Virgin Islands.

The U.S. Internal Revenue Code limits the power of the Virgin Islands government to reduce its income tax (sec. 934). The Virgin Islands may not reduce its taxes attributable to income derived from sources within the United States. With respect to non-U.S. source income, the Virgin Islands may not reduce its corporate tax except to U.S. and V.I. corporations that meet a so-called "80-50 test." This test allows the Virgin Islands to reduce taxes only for those U.S. and V.I. corporations that have derived for the past three taxable years (or applicable part thereof) at least 80 percent of their gross income from V.I. sources and at least 50 percent¹ of their gross in-

¹ Under the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, the percentage of a corporation's gross income that must be derived from the active conduct of a trade or business in the Virgin Islands is increased from 50 percent to 65 percent. This increase will be phased in over three years. For taxable years beginning after Dec. 31, 1982, the percentage limitation will be 55 percent, for taxable years beginning after Dec. 31, 1983, the percentage limitation will be 60 percent, and for taxable years beginning after December 31, 1984 and thereafter the percentage limitation will be 65 percent.

That Act did not affect the percentage—80 percent—of gross income that must be derived from Virgin Islands sources.

B. Provisions Relating to Social Security Disability Insurance (DI)

1. Continuation of DI benefits to certain individuals pursuing appeal (sec. 2 of the bill and sec. 223 of the Social Security Act)

Present Law

A social security disability insurance (DI) beneficiary who is found by the State agency to be no longer eligible for benefits continues to receive benefits for two months after the month in which he ceases to be disabled. (As an administrative practice, individuals are now generally found to be "not disabled" no earlier than month in which the agency makes the termination decision.) The individual may request a reconsideration of the decision and, if the denial is upheld, he may appeal the decision to an Administrative Law Judge (ALJ). The individual is not presently eligible for benefits during the appeals process. However, if the ALJ reverses the initial termination decision, benefits are paid retroactively.

Reason for Change

In the early stages of the continuing disability investigations (CDI) review process, while reviews have been focused on cases most likely to be found ineligible, States have been terminating benefits in approximately 45 percent of the cases reviewed. Of those cases which appeal, approximately 65 percent have benefits reinstated by an administrative law judge. This wide variation between the decisions made by State agencies and ALJs, a long recognized problem, stems from a number of factors. For example, the beneficiary can introduce new medical evidence at the ALJ hearing; the ALJ hearing is the first face-to-face contact between the reviewed beneficiary and a decision-maker; and the standards of disability used by State agencies and ALJs differ in some important aspects.

The committee believes that the lack of uniformity of decisions between State agencies and ALJs is a fundamental problem in the disability determination and appeals process which must be dealt with administratively and must be carefully considered when the Committee takes up substantive legislation. In the meantime, the Committee believes that some emergency relief is warranted for workers who are having benefits terminated by State agencies and then—in more than half the cases appealed—having their benefits reinstated by an ALJ.

The committee does not intend that its decision to extend benefits during the appeals process should be considered a judgment that it disagrees with the standards being applied by the State agency. It is clearly the responsibility of the administering agency to make the

policy determinations which implement a statute. The Social Security Disability Amendments of 1980 properly mandated a vigorous effort to eliminate ineligible individuals from the benefit rolls. This legislation does not in any way represent a reversal of that mandate but rather is a temporary expedient to help deal with some of the problems incident to the implementation of that mandate.

The committee expects that every effort will be made to collect overpayments from beneficiaries in cases where the final decision is to terminate benefits. While there is provision to waive overpayments in cases where recovery is clearly inappropriate, the Committee expects such waivers to be granted only when fully justified and after all alternatives for repayment—including repayment over a period of time—have been explored.

Explanation of Provision

The committee amendment will continue DI benefits and medicare coverage (at the individual's option) through the month preceding the month of the hearing decision for terminated beneficiaries pursuing an appeal. These additional DI payments would be subject to recovery as overpayments, subject to the same waiver provisions now in current law, if the initial termination decision were upheld.

Effective Date

This provision will be effective for termination decisions occurring between the date of enactment and July 1, 1983, but in no case would payments be made for months after June 1983. Cases now pending an ALJ decision would also be covered by this provision, although lump sum back payments would not be authorized. Individuals terminated before the date of enactment who have not appealed the decision would qualify for continued benefits only if they are still within the allowable period for requesting a review.

2. Secretarial authority to control flow of continuing disability investigation reviews (sec. 3 of the bill and sec. 221(i) of the Social Security Act)

Present Law

As mandated by the Social Security Disability Amendments of 1980, all DI beneficiaries except those with permanent impairments must be reviewed at least once every 3 years to assess their continuing eligibility. Beneficiaries with permanent impairments may be reviewed less frequently. The provision in present law specifies a minimum level of review.

Reason for Change

The committee believes that the requirement of the 1980 amendments mandating a periodic review of the continuing eligibility of disability beneficiaries is essential for ensuring that benefits go only to those who are disabled within the meaning of the law. The Committee also believes that every effort should be made by the Secretary, in co-

operation with the States, to ensure that these reviews are carefully considered and processed in a timely fashion.

The committee recognizes that some States may have experienced unavoidable difficulties in implementing the periodic review procedures. For this reason, the Committee amendment authorizes the Secretary to take into account the capabilities and workloads of the State agencies in assigning cases to the States for review. To some extent, actions already implemented administratively may have relieved the situation in some States, but this amendment will make clear the Secretary's authority to provide such relief even if this means that the statutory schedule of reviewing one-third of the caseload each year cannot *initially* be met. The Committee emphasizes, however, that it continues to view the integrity of the disability rolls as a matter of high national priority which must be achieved in all States by the prompt implementation of a thorough program of periodic review.

The committee notes that the full cost of State agency administration is borne by the social security trust funds. It is expected that the Secretary will request and make available to the States adequate resources to achieve full compliance with the 1980 amendments as rapidly as possible. In particular, the Committee insists that this authority shall be used only where the State is unable to carry out the full workload despite a good faith effort to achieve the necessary staffing and otherwise take advantage of the resources made available. The Committee also expects the Administration to undertake all necessary actions to assure that the program of periodic review is properly and evenhandedly implemented on a nationwide basis.

Explanation of Provision

The committee amendment provides the Secretary of Health and Human Services the authority to slow—on a State-by-State basis—the flow of cases sent to State agencies for review of continuing eligibility. The Secretary is instructed to take into consideration State workload and staffing requirements, and is authorized to slow reviews only in States that demonstrate a good faith effort to meet staffing requirements and process claims in a timely fashion.

Effective Date

This provision will be effective on enactment.

3. Medical evidence requirement (sec. 4 of the bill and sec. 221 of the Social Security Act)

Present Law

Although current law does not specify a time period for the collection of medical evidence, current procedures, detailed in the guidelines used by State agencies, require the Secretary to seek to obtain all medical evidence from all persons or institutions which have diagnosed or treated the individual within the 12-month period preceding the review of an individual's continuing eligibility.

The adoption of this procedure was announced by the Administration in May 1982. Previously, any requirements as to the length of the period over which medical evidence should be sought were left up to the States. For some individuals, medical evidence was gathered over more than a 12-month period. For others, medical evidence was gathered over a shorter period.

Reason for Change

The committee regards as a high priority the careful development and consistency of decisions to terminate or continue disability benefits. This provision is intended to contribute to both of these objectives. It is not the committee's intention that this provision require the Secretary to pay for medical evidence which is not useful for an evaluation of the individual's impairment.

Explanation of Provision

The committee amendment puts into law the requirement that the Secretary must attempt to seek and obtain all relevant medical evidence from all persons or institutions which have diagnosed or treated the individual within the 12-month period preceding the review of an individual's continuing eligibility.

Effective Date

This provision will be effective on enactment.

4. Report to Congress (sec. 5 of the bill and sec. 221(i) of the Social Security Act)

Present Law

There is no requirement for periodic reporting to the Congress by the Secretary of Health and Human Services with respect to continuing disability investigations.

Explanation of Provision

The committee amendment requires the Secretary to report to the Senate Finance Committee and the House Ways and Means Committee semiannually on the number of: Continuing eligibility reviews, termination decisions, reconsideration requests, and termination decisions which are overturned at the reconsideration or hearing level.

Effective Date

This provision will be effective on enactment.

Determination of the amount of paperwork.—The bill will involve some paperwork requirements for the Virgin Islands and affected taxpayers in determining withholding changes under the bill.

Provisions relating to social security disability insurance

The disability insurance amendments will make additional benefits available to certain individuals. While there may be some additional forms which must be filed as a consequence of this change, the economic circumstances of affected individuals will clearly be improved. The bill will not impact on personal privacy.

Other Matters

Consultation with Congressional Budget Office on Budget Estimates

In accordance with section 403 of the Budget Act, the committee advises that the Director of the Congressional Budget Office has examined the committee's budget estimates and agrees with the methodology used and the resulting estimates (as indicated in Part III of this report). The Director submitted the following statement:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., September 30, 1982.

HON. ROBERT DOLE,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In accordance with Section 403 of the Budget Act, the Congressional Budget Office has examined H.R. 7093, as ordered reported by the Committee on Finance on September 28, 1982. The bill reduces the 30 percent tax on non-Virgin Island passive investment (dividends, royalties, interest) to 10 percent. However, the bill will continue the current 30 percent rate for dividends paid to individuals out of earnings and profits accumulated during taxable years beginning before the effective date of the bill.

This bill does not provide any new or increased tax expenditures. The Congressional Budget Office also estimates that the bill will have a negligible effect on budget receipts.

A Disability Insurance provision would permit payments to cases appealing a termination decision through an administrative law judge hearing. The provision would permit payments through July 1983. This would add an estimated \$60 million to federal outlays in fiscal year 1983 and would reduce federal outlays by \$20 million in 1984. Any outlay effects in fiscal years 1985 through 1987 and the budget authority effects in all years would be negligible.

Sincerely,

RAYMOND C. SCHEPPACH
(For Alice M. Rivlin, Director).

New Budget Authority

In compliance with section 308(a)(1) of the Budget Act, and after consultation with the Director of the Congressional Budget Office, the committee states that the bill has a negligible effect on budget authority in all years.

VI. ADDITIONAL VIEWS OF SENATOR LONG ON H.R. 7093

The social security disability program was enacted in 1956. At the time it was passed, Congress believed it was adopting a narrowly drawn program which would serve only the most severely disabled. The actuaries projected that its cost would be modest and that it could be financed over its entire future history by a tax rate of less than one-half of one percent. Over the years, these early cost estimates have proven much too low. The number of people drawing benefits has grown far beyond anything that was anticipated in 1956. The long-range cost of the program is now projected to be some three and one-half times as great as was expected in 1956. By 1980, it was clear to Congress that this was a program out of control.

In 1980, the Congress enacted legislation designed to bring the social security disability insurance program back under control. A major element of the 1980 amendments was a requirement that the Administration begin a thoroughgoing periodic review of the eligibility of all beneficiaries. This review has been undertaken and, as was anticipated, a large portion of the cases reviewed have been found to be ineligible. Yet the Finance Committee in this bill recommends the extraordinary procedure of continuing to pay benefits to individuals who have been found to be ineligible for those benefits until they have exhausted a lengthy administrative appeals process.

I believe that continuing benefits is a fundamentally incorrect approach to this situation. The individuals being terminated from the disability rolls are people who have been found not to meet the requirements for eligibility. The present review process was mandated because of deep Congressional concern that the cost of the disability program had grown out of control. Lax administration was a major reason for the uncontrolled growth of the program. Because of this lax administration, many people were put on the benefit rolls who did not meet the stringent requirements that Congress established for this program.

The social security disability program from its very inception was intended as insurance against the virtually total loss of earnings ability arising from severe disabilities. Time and again Congress has reaffirmed the intent to limit benefits under this program only to those people who cannot work. Unfortunately, the program has not always been administered in a way which carries out this mandate. As a result, individuals have been put on the benefit rolls even though their disabilities are not so severe that they are no longer capable of substantial work activity. Some of these individuals are in fact handicapped, but they are not so disabled as to meet the standards of the social security disability program.

The Committee proposal will result in significant expenditures of social security trust fund monies. These expenditures will go to pay benefits primarily to people who do not qualify for those benefits. While the legislation provides for recovering these incorrect payments at a later date, most of those payments will not in fact be recovered.

The Administration believes that they will be able to get back about half of the incorrect payments, and that may be a highly optimistic estimate. The payment of benefits during appeal will tend to aggravate the existing serious problems which exist within the social security appeals system. Moreover, there is a danger that this legislation will be viewed as undermining the mandate of the 1980 Amendments for vigorous administration to assure that benefits are paid only to eligible individuals.

THE NATURE OF THE SOCIAL SECURITY DISABILITY PROGRAM

When the social security disability program was enacted in 1956, it was intended to be a program for those individuals who are so disabled that they cannot engage in any kind of substantial work activity. There are many people who suffer handicapping ailments, and these individuals are deserving of great sympathy. However, the social security disability program was not intended as a pension to be paid to anyone with a handicap. If the social security trust funds are to be used to pay benefits to all those who have suffered a medical condition which restricts their earnings capacity, the Congress will need to enact very substantial increases in the social security tax rate to fund the program.

This is not to say that Congress should not address the problems of handicapped individuals. A great deal can be done through a variety of programs to assist these individuals to regain the ability to work and to encourage the expansion of employment opportunities. Consideration needs to be given to improving those programs and to strengthening the incentives in the tax laws for hiring the handicapped. But the social security disability insurance program is based on a different premise and addresses a different population. The social security program is insurance against that catastrophic situation in which a worker becomes so disabled that he has totally lost the ability to support himself.

The limited intent of Congress with respect to this program can be seen by looking back at its legislative history. In 1957, when the program was newly enacted, the actuaries projected that, its costs would represent less than one-half percent of taxable payroll. By 1980, that cost was projected at 1.5 percent of payroll—more than 3½ times as much.

Despite the intent of Congress that this should be a program narrowly limited to people who have totally lost the ability to earn a living, there has been a continual tendency to put on the rolls individuals who are less severely disabled. In part this may arise from a misunderstanding of the purposes of the program. In part it may arise from the unwillingness to expend the funds necessary to administer the program tightly.

The Congress has reaffirmed its original intent to restrict this program to the most severely disabled individuals when it has reviewed the program. In 1967, for example, it appeared that courts were applying a rule which would give benefits to any individual with a disability sufficiently severe to keep him from doing his usual work or any other work available in his locality.

DI FINANCIAL FORECASTS IN EARLIER TRUSTEES' REPORTS

[Intermediate Assumptions]

Year of earlier trustees' report	Long-range cost (in percent of taxable payroll)	Cost estimates for CY 1980 [dollars in billions]
1957.....	0.42	\$1.0
1960.....	0.35	1.5
1965.....	0.63	2.0
1967.....	0.85	3.2
1972.....	1.18	NS
1977.....	3.68	17.4
1980.....	1.50	¹ 15.9
1982 ¹	1.50	² 15.9

¹ Actual for 1980.² Estimate.

NS—Not shown in report.

Source: Congressional Research Service, July 1982.

DISABILITY INSURANCE PROGRAM COSTS, 1957-82

[In millions]

Calendar year	Total costs
1957.....	\$59
1958.....	261
1959.....	485
1960.....	600
1961.....	956
1962.....	1,183
1963.....	1,297
1964.....	1,407
1965.....	1,687
1966.....	1,947
1967.....	2,089
1968.....	2,458
1969.....	2,716
1970.....	3,259
1971.....	4,000
1972.....	4,759
1973.....	5,973
1974.....	7,196
1975.....	8,790
1976.....	10,366
1977.....	11,946
1978.....	12,954
1979.....	14,186
1980.....	15,872
1981.....	¹ 17,658
1982.....	¹ 18,508

¹ Estimated based on the Alternative II-B assumptions contained in the 1982 OASDI Trustees' Report.

Source: Social Security Bulletin, Annual Statistical Supplement, 1980.

DI BENEFICIARIES, YEAR-BY-YEAR, 1957-82

Calendar year	Disabled workers	Total DI beneficiaries ¹
1957.....	149,850	149,850
1958.....	237,719	268,057
1959.....	334,443	460,354
1960.....	455,371	687,451
1961.....	618,075	1,027,089
1962.....	740,867	1,275,105
1963.....	827,014	1,452,472
1964.....	894,173	1,563,366
1965.....	988,074	1,739,051
1966.....	1,097,190	1,970,322
1967.....	1,193,120	2,140,214
1968.....	1,295,300	2,335,134
1969.....	1,394,291	2,487,548
1970.....	1,492,948	2,664,995
1971.....	1,647,684	2,930,008
1972.....	1,832,916	3,271,486
1973.....	2,016,626	3,558,982
1974.....	2,236,882	3,911,334
1975.....	2,488,774	4,352,200
1976.....	2,670,208	4,623,757
1977.....	2,837,432	4,860,431
1978.....	2,879,774	4,868,490
1979.....	2,870,590	4,777,412
1980.....	2,861,253	4,682,172
1981.....	2,776,519	4,456,274
1982 est. ²	2,723,000	4,374,000

¹ Includes spouses and children of disabled workers.

² 1982 OASDI Trustees' Report, Intermediate II-B assumptions.

Source: Social Security Bulletin, annual statistical supplement, 1980.

The Congress felt this was a far broader definition of disability than was appropriate for the social security disability insurance program. To reemphasize the original intent, Congress amended the law to make it clear that an individual "shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy

exists for him, or whether he would be hired if he applied for work" (sec. 223(d) of the Social Security Act).

Despite the clear Congressional intent that the social security disability insurance program be limited to the most severely disabled, the program continued to experience growth beyond anything that could be explained by changes in the legislation or demographic trends. The annual costs of the program increased from a little more than \$250 million in 1958 to over a billion dollars in 1962, to more than \$3 billion by 1970, more than \$10 billion by 1976 and more than \$18 billion in 1982.

According to an analysis done in 1978 by former Chief Actuary Robert Myers, the incidence of persons receiving disability benefits increased from 4.5 per one thousand insured workers in 1968 to 6.0 per one thousand in 1972, and to 6.9 per one thousand in 1975—in effect a 50 percent increase over a seven-year period in the rate at which workers were coming onto the disability rolls. There is no evidence to indicate that this increase was in any way based on real increased incidence of disabling conditions among the population at large.

A June, 1977 study by the actuaries of the Social Security Administration cited a variety of factors as responsible for the growth in the benefit rolls. Possible explanations included the increased attractiveness of benefits under a system in which benefit levels had been substantially increased, changing attitudes on the part of individuals with impairments, and increased emphasis on vocational factors resulting in more allowances on appeal. The actuaries also cited the results of trying to hold down administrative costs during a period of increased caseloads and the tendency in such circumstances to give claimants the benefit of the doubt. This problem was described by the actuaries as follows:

All of this put tremendous pressure on the disability adjudicators to move claims quickly. As a result the administration reduced their review procedures to a small sample, limited the continuing disability investigations on cases which were judged less likely to be terminated, and adopted certain expedients in the development and documentation in the claims process. Although all of these moves may have been necessary in order to avoid an unduly large backlog of disability claims, it is our opinion that they had an unfortunate effect on the cost of the program.

By claiming that it is difficult to maintain a proper balance between sympathy for the claimant and respect for the trust funds, we do not mean that disability adjudicators consciously circumvent the law in order to benefit an unfortunate claimant. What is meant is that in a public program designed specifically to help the people, such as Social Security, whose operations are an open concern to millions of individuals, and where any one decision has an insignificant effect on the overall cost of the program, there is a natural tendency to find in favor of the claimant in close decisions. This tendency is likely to result in a small amount of growth in disability incidence rates each year, such as that experienced under the DI program prior to 1970, but it can become highly significant during long periods of difficult national economic conditions." (SSA Actuarial Study No. 74, January 1977, p. 8.)

COMPARISON OF CONTINUING DISABILITY INVESTIGATIONS (CDI'S)
PROCESSED TO TOTAL DISABLED-WORKER BENEFICIARIES OVER THE YEARS

Fiscal year	CDI's processed (DI and concurrent cases only)	DI-worker beneficiaries (in millions)	Number of CDI's per 1,000 DI-worker beneficiaries
1970	¹ 167,000	1.493	111.8
1973	¹ 142,000	2.017	70.4
1974	¹ 120,000	2.237	53.6
1975	¹ 116,000	2.489	46.6
1976	¹ 129,000	2.670	48.3
1977	107,220	2.834	37.8
1978	83,651	2.880	29.0
1979	94,084	2.870	32.8
1980	94,550	2.861	33.0
1981	168,922	² 2.835	59.6
Oct. 1, 1981 to June 28, 1982	243,785	² 2.723	89.5

¹ Figures provided by SSA in 1977, but not currently verifiable.

² Estimates based on intermediate II-B assumptions in the 1982 Trustees' Report.

Source: SSA and Social Security Bulletin, Annual Statistical Supplement, 1980.

THE 1980 AMENDMENTS

In view of the enormous growth in disability insurance program costs and caseloads, the Congress enacted legislation in 1980 designed to bring the program back under control. The 1980 legislation established limitations on benefit amounts designed to deal with the problem of a program in which benefit levels were unreasonably high in relation to earnings levels. Congress was, however, also concerned with the evidence of loose administration, and mandated several changes designed specifically to tighten up the disability determination process. In order to assure that improper awards to new claimants were avoided, Congress required the Social Security Administration to reinstate its former practice of reviewing most State agency allowances before payments are started. To deal with the problem of improper allowances on appeal, the 1980 Amendments required the Secretary to begin reviewing cases which are allowed in the appeals process. Under this provision, the Social Security Appeals Council is required to reexamine a significant sample of cases decided by administrative law judges and to reverse those cases which have been improperly decided.

The 1980 legislation also required that the Administration report the progress in implementing this review program and provide an analysis of the reasons why administrative law judges so frequently overturn initial agency decisions.

Finally, Congress in the 1980 law specifically required that all disability beneficiaries be reexamined on a periodic basis. This require-

ment was designed to assure that those who were not eligible for benefits would not continue on the rolls indefinitely once they began receiving benefits. In general, the Administration was required to review each claimant's eligibility at least once every three years; a less frequent review is permitted in cases which are determined to be permanent.

INDIVIDUALS BEING TERMINATED ARE INELIGIBLE

The Congress required a periodic review in the 1980 amendments because of indications that many ineligible people were, in fact, receiving benefits. The rapid growth of the disability caseloads over the preceding 10 years was one indication of this. The substantially reduced level of administrative review during that same period also led to concern that ineligible persons were receiving benefits. Subsequent to the enactment of the 1980 amendments, these concerns were verified in studies conducted both by the Social Security Administration and the General Accounting Office. In March 1981, the GAO issued a report entitled "More Diligent Follow-up Needed To Weed Out Ineligible Social Security Administration Disability Beneficiaries." Based on the evidence then available, this report concluded that "there could be about 584,000 persons on the DI rolls who may not meet the program's eligibility criteria." The annual benefit drain for cash benefits alone (not including medicare) was estimated to be as high as \$2 billion. On the basis of its findings, the GAO report recommended that the Department give high priority to implementing a more vigorous continuing disability review program.

On the basis of the legislative mandate in the 1980 amendments and the findings of its own internal studies and those of GAO, the Social Security Administration did undertake a vigorous program of reviewing the eligibility of disabled beneficiaries. During the first eight months of fiscal year 1982, a total of 267,000 reviews were completed. Forty-seven percent of these cases (121,000) were found to be ineligible. Although this is a very high rate of ineligibility, it is consistent with the evidence found in earlier studies. In conducting these reviews, the Administration has utilized techniques designed to target the first reviews on those parts of the caseload where ineligibility was more likely to be found. During the Finance Committee consideration of this bill, an Administration spokesman stated that the overall ineligibility rate is expected to be about 25 percent by the time the process is fully implemented.

While these continuing disability reviews are conducted by State agencies, the Social Security Administration monitors the accuracy of their decisions by conducting a sample reexamination of State agency findings. For the period from October 1981 through March 1982 (the latest available findings) these quality control samples show a 97.5 percent net accuracy rating. In other words, after reexamination of all of the sampled cases (including obtaining additional evidence where this seemed appropriate), the Social Security Administration would have disagreed with the finding of the State agency in only 2½ percent of the cases. This means that by the standards of disability which are applied by the agency, nearly all the cases being terminated are, in fact, ineligible for benefits.

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CONTINUING DISABILITY INVESTIGATION (CDI) CONTINUANCES AND
CESSATIONS BY STATE AGENCIES, DI AND SSI COMBINED, FISCAL YEARS 1977-82¹

Fiscal year	Total number of CDI reviews	Continuances	Cessations	Continuance rate (in percent)	Cessation rate (in percent)
1977.....	150,305	92,529	57,776	62	38
1978.....	118,819	64,097	54,722	54	46
1979.....	134,462	72,353	62,109	54	46
1980.....	129,084	69,505	59,579	54	46
1981.....	208,934	110,134	98,800	53	47
10/1/81-5/28/82.....	266,725	145,321	121,404	54	47

¹ Reflect continuance and cessation rates only at the State agency level—not at the district office or at the hearing or appeal levels of adjudication. These figures differ from the previous table in that they exclude CDI's where no new medical determination of disability by the State agency was required. Other factors have affected the individual's entitlement, such as his return to work.

Source: SSA, July 1982.

REQUESTS FOR ALJ HEARINGS—RECEIVED, PROCESSED, AND PENDING TOTAL CASES

Fiscal years	Requests received	Processed	Pending (end of year)
1979.....	226,200	210,775	90,212
1980.....	252,000	232,590	109,636
1981.....	281,700	262,609	128,164
1982.....	² 326,300	300,000	² 155,064

¹ Includes DI, OASI, SSI, and Black Lung cases.

Source: Estimate provided by SSA, OHA, July 1982.

ADMINISTRATIVE LAW JUDGE REVERSAL RATES—DISABILITY INSURANCE
INITIAL DENIALS AND TERMINATIONS, FISCAL YEARS 1979-82

Fiscal year	Percent of cases reversed	
	Initial denials	Terminations
1979.....	56.4	59.5
1980.....	59.4	63.8
1981.....	59.0	61.5
1st quarter 1982.....	57.3	65.4

Source: SSA, July 1982

PROBLEMS IN THE APPEALS PROCESS

If an individual's benefits are terminated because he is found no longer to be disabled, he is entitled to seek a further review of the issue. The first review takes place as a matter of reconsideration by a different decisionmaker in the State agency. Most reconsideration decisions uphold the initial finding of ineligibility. The claimant then is entitled to ask for a hearing before an administrative law judge. At the present time, the administrative law judges are reversing a very high proportion of cases appealed to them. During the first quarter of 1982, 65 percent of terminations which were appealed to administrative law judges were being restored to benefit status. While this is a very high reversal rate, it is not strikingly different from the administrative law judge reversal rate in prior years, nor from the administrative law judge reversal rate of initial claims.

The high reversal rates at the hearings level have been a matter of concern to the Congress for a number of years. On its face, a system in which most appealed cases are reversed is a system in trouble. Simply as a workload matter, such a situation leads to an unduly large number of appeals. The committee proposal to pay benefits during appeal will aggravate this problem. Moreover, a high reversal rate tends to cast doubt on the validity of the entire decisionmaking process and to invite efforts to game the system.

The 1980 amendments included a requirement that the Social Security Administration conduct a study of the factors involved in the large numbers of ALJ reversals. This study found that markedly different eligibility standards were being applied in the appeals process from the standards used by the agency. In a sample of administrative law judge decisions, the Social Security Office of Assessment using agency standards would have allowed 13 percent of the sample—while the administrative law judges had allowed 64 percent of the sample. This study indicates that a very significant part of the administrative law judge pattern of high reversals occurs because the appeals process simply does not follow the same eligibility standards as the agency.

There will always be some reversals which can be attributed to differences of judgment in close cases, evidence obtainable only through personal appearance, and changes in condition between initial decision and hearing. But reversals for these reasons represent only a small part of the caseload. Most reversals are due to the application of easier eligibility standards.

There can be no justification for continuing a system in which different standards of eligibility are applied at the appeals level than are applied at the initial determination level. Such a situation invites universal appeals, denies those who do not appeal of a fair opportunity to receive benefits, and creates a revolving door situation in which one part of the agency puts an individual on the rolls after another part of the same agency has taken him off the rolls. It is the responsibility of the administering agency, in this case the Social Security Administration, to develop the procedures and guidelines which will carry out the requirements of a law. Policy decisions should be made by the agency and should be carried out by all parts of the agency including those charged with conducting hearings. It is not the function of an

Table 1. Percent Distribution of Sample Case Allowances and Denials, by Decision-maker and Basis for Decision ^{1/}

	Original ALJ Decision	Appeals Council Decision	Office of Assessment Decision Using DDS Standards
ALLOWANCES			
Total	64%	48%	13%
Medical alone	18	15	6
Medical/Vocational inability to engage in SGA:			
Directed by medical-vocational rule	14	11	5
Specific reasons:			
RFC less than sedentary	18	9	0
Pain combined with significant impairment(s)	5	3	0
Mental disorders combined with significant physical impairment(s)	5	4	(2/)
Other medical/vocational	5	6	2
DENIALS			
Total	36	52	87
Impairment not severe	11	16	39
Impairment does not prohibit past work	9	13	28
Directed by medical-vocational rule	13	19	13
Impairment does not prohibit other work	1	2	4
Other	2	3	3

NOTE: Detail may not add to totals due to rounding.

^{1/} Percentages shown are for the combined total of DI and SSI claims. Although there are some differences between the allowance/denial rates for DI claims and SSI-claims (e.g., the Appeals Council would have allowed about 49% of DI claims and 45% of SSI claims), these differences do not appear to be significant and do not affect the findings of the review.

^{2/} About 0.4%.

Source: SSA January 1982 Study

administrative law judge to make agency policy. It is his function to assure claimants that the agency policy is being carried out in their case. This responsibility of the administrative law judge was described in a 1977 study of the Social Security appeals process by the Center for Administrative Justice. The final report of that study describes the proper roll of the administrative law judge as follows:

The protection of ALJ decisional independence in the APA is significant. Once appointed the ALJ's position is permanent; he may be removed only "for cause" after formal adjudicatory hearing. Moreover, the ALJ's compensation is determined by the Civil Service Commission, not by his agency. Cases must be assigned in rotation, the ALJ may not be assigned tasks inconsistent with his duties as an ALJ and, with respect to the *facts* at issue in a particular case, the ALJ may not be approached by anyone, including the employing agency, save on the record. Moreover, the ALJ may not be made subject to the supervision or control of any person who has investigative or prosecuting functions for the agency.

On the other hand, certain aspects of the ALJ's activities are clearly subject to agency control. ALJ's are not "policy" independent. They represent an extension of "the agency" and the agency may control their exercise of discretion by regulation, guidelines, instructions, opinions and the like in order to attempt to produce decisions as similar as possible to those "the agency" would have made. There is no prohibition even on consultation with agency employees on questions of law or policy in a particular case.

(Sources: *Final Report: Study of the Social Security Administration Hearing System*. Center for Administrative Justice, October 1977, p. 244-5.)

It appears that the Social Security Administration in the past has not carried out its responsibility to assure that administrative law judges do in fact implement agency policy as to how and under what standards the question of disability is to be determined.

This situation should be greatly improved in the near future. The Social Security Administration has undertaken to publish in Social Security Rulings (which are binding on administrative law judges) a much more detailed explanation of the criteria to be applied in determining whether or not an individual is eligible for disability benefits. The greater part of these rulings will have been published by the end of October of this year and this project is expected to be essentially completed with the publication of the January, 1983 Social Security Rulings. The Administration is to be commended for undertaking to correct this problem and should continue to monitor the situation and to publish further guidelines as necessary.

To assure that the administrative law judges are in fact carrying out the agency policy as published in these rulings, the Social Security Appeals Council has the ongoing responsibility of reviewing cases allowed by administrative law judges. This responsibility was reaffirmed in the 1980 legislation and the Administration should give a high priority to implement that responsibility. If the agency suc-

ceeds in conforming the policy applied in the appeals process to the authoritative agency policy standards, the rate of reversals on review should fall dramatically. This in itself should tend to reduce the appeals workload to more manageable levels, since claimants will no longer be encouraged to appeal in all cases (as they are by the present system). Once these changes are fully implemented, it can be expected that reversals at the hearing level will tend to occur only where there is in fact a failure to apply the agency standards at the initial and reconsideration levels, or where the claimant's condition has in fact worsened since the initial agency determination.

INITIAL PROBLEMS ARE BEING CORRECTED

The present Administration is to be commended for moving rapidly and effectively to implement the review requirements mandated by the Congress. It is unfortunately inevitable that there will be some difficulties encountered in undertaking any major new initiative. In the case of the disability review process, this situation was aggravated by the very large number of cases involved (267,000 during the first eight months of fiscal 1982) and by the complications of operating under contractual arrangements with a network of State agencies.

Sadly, there were some cases of improper terminations and even some cases of terminations involving individuals with such severe disabilities as to leave no room for doubt. It is remarkable that such situations were rare and that the Administration has been able to maintain a 97.5 percent accuracy rate. Still, every effort should be made to avoid burdening those individuals who are without any question eligible, and the Administration has in fact been sensitive to this need.

Since the implementation of this program, the Administration has made numerous changes in its procedures directed specifically at assuring that truly eligible individuals are continued in benefit status and, insofar as appropriate, are spared the burden of unnecessary reviews.

A letter to the Committee on Finance from the Commissioner of Social Security outlines the following twelve different steps the agency has taken to improve its procedures in ways which help assure a high degree of accuracy:

EXCERPT FROM SEPTEMBER 16, 1982, LETTER FROM COMMISSIONER OF SOCIAL SECURITY

1. In March, SSA initiated a policy of determining that, in general, a person's disability ceases as of the time the beneficiary is notified of the cessation. This change reduces situations where the beneficiary is faced with the need to pay back past benefits because of a retroactive determination.

2. Since May, SSA has mandated that States review *all* medical evidence available for the past year—a directive which ensures that every State is looking at every piece of evidence that might be pertinent to a case.

3. SSA has underway, in two States, a study to test the value of obtaining more than one special mental status examination in cases where evidence from the beneficiary's

treating source is incomplete or inadequate. This is intended to determine whether a person's mental condition can drastically change from one day to another. One criticism of SSA's practice of getting only one mental status examination is that it gives a misleading "snapshot" of a person.

4. Since March, SSA has required State agencies to furnish detailed explanations of their decisions in all cases in which a person's disability has ceased.

5. To insure quality in CDI cases, SSA conducts a quality review of a sample of cases before benefits are stopped. In June 1982, SSA doubled the number of quality reviews of termination cases. The quality has been holding very high at 97.5 percent. In addition, to demonstrate the importance of quality in the CDI process, SSA established an interim accuracy goal for the State agencies will cut waiting for publication of regulations.

6. SSA has consistently monitored State agency resources and workloads closely and adjusts the flow of cases to the individual States to avoid backlogs when problems have arisen in their acquiring adequate resources. The selective moratoriums on new CDI cases that SSA has implemented for August and September (and even earlier in some States) has been easing problems in specific States that have had unusually large backlogs.

7. Starting in October, SSA will use a new procedure for beginning a CDI review: each beneficiary will have a face-to-face interview with an interviewer in the local Social Security office. The interviewer will explain how the review works and what the beneficiary's rights are, obtain information about the beneficiary's medical care and treatment and current condition, and—in some cases—conclude the review process where it is clearly warranted based on the beneficiary's current medical condition.

This will correct the single most glaring anomaly in the CDI process. Recipients whose cases are selected for review under the 1980 Congressional mandate rarely, if ever, come face-to-face with a decisionmaker until and unless the case is pursued to the third level of review and appeal—a process which may drag on as much as 6 months to a year after benefits have been stopped. This one flaw in the program is perhaps more to blame than any other factor for the seemingly senseless "horror stories" we have all seen from time to time of people being dropped from the rolls despite glaringly obvious disabilities.

8. To improve the quality of determinations in difficult cases where it is necessary to determine a person's capacity to do work-related activities despite a severe impairment, SSA is requiring that the determinations as to remaining capacity be more detailed and explicit so that the basis for the final decision is clear.

9. SSA has taken many actions to improve the quality of consultative examinations purchased by the Government in

cases where medical evidence from a person's physician is unavailable or incomplete.

10. SSA has been very sensitive to the need for special handling of cases involving psychiatric impairments. SSA has met with mental health groups to obtain their recommendations for improvements and is reevaluating all guidelines for evaluation of mental impairments. SSA has also encouraged the States to increase the number of psychiatrists on their staffs in order to enhance their ability to review cases involving mental impairments. Secretary Schweiker has asked the American Psychiatric Association for assistance in recruiting psychiatrists for the States.

11. SSA has added more than 140 Administrative Law Judges to what is already perhaps the largest single adjudicative system in the world, bringing their total number to more than 800 and providing them with significantly more support staff to help reduce the backlog of cases that has been a chronic problem in past years.

12. Based on our findings in the first year of the CDI program, SSA has broadened the definition of the permanently disabled who need not be subject to the every-three-year CDI process mandated under the law. As a result, SSA expects to exempt an additional 165,000 beneficiaries from the CDI process during the next fiscal year—which will mean reducing the total from about 800,000 to about 640,000, a major reduction in workloads for the State agencies.

Included in these measures is an important change under which a personal interview is conducted by a Social Security Administration employee before a case is even sent to a State agency for review. This personal interview assures that claimants will be acquainted with the implications of the process and will have the opportunity to present their views and to make available any relevant evidence. Moreover, the face-to-face interview creates a situation in which obviously inappropriate reviews can be detected at the very beginning of the process. In such situations, the case is not even sent to the State agency but is referred back to the Social Security central office with a recommendation that further review be discontinued.

These actions should reduce to an absolute minimum the incidence of improper terminations. Together with the administrative steps being taken to improve the appeals process, these changes eliminate any possible basis for continuing benefit payments beyond the point of the initial State agency determination.

FINANCE COMMITTEE APPROACH INADVISABLE

The Committee has recommended an approach which would continue benefits during the appeals process. This approach has nothing to recommend it. If the bulk of initial decisions denying benefits were incorrect, the proper approach would be to change the initial decision process rather than to pay benefits to those who happen to appeal that initial decision. In fact, however, the evidence available to the Committee does not indicate that the bulk of initial decisions are wrong.

Rather, it indicates that over 97 percent of the decisions are correct. Consequently, the Committee bill will result in spending social security trust fund money primarily to pay improper benefits. Some of this money will be subsequently recovered; most of it will not. Except in those cases where the individual's benefit is continued on appeal (and this will frequently be an improper continuation) the amendment does nothing but postpone the day of reckoning. Moreover, it will leave the terminated beneficiary with the burden of a substantial overpayment at that point.

The implications of the Committee amendment may be even more than the short-term improper expenditure of many millions of dollars in social security trust funds. The history of the social security disability program seems to show a fair degree of volatility in the application of adjudicative standards. The Congress has faced a continuing need to reemphasize its original intent that the definition of disability be applied strictly and narrowly. In the 1980 Amendments Congress spoke forcefully and, thus far, effectively to this issue. There is a distinct danger that these amendments would be viewed by all adjudicators as a reversal of this Congressional intent. This bill could be seen as a Congressional judgment that most, or a substantial proportion, of the agency's terminations are incorrect. If this occurs, it could cause the State agencies to allow more claims.

In addition, the Committee provision is bound to have substantial impact on the appeals process, probably in ways which will undermine the attempts of the Administration to bring the appellate process back into line with the agency policy. Simply on a workload basis, the decision to pay benefits through the hearing level will stimulate additional appeals from individuals with little expectation of ultimately winning reinstatement. In addition, the hearings officers like the State agencies may read into this legislation a subtle message that Congress is reversing its earlier concern over the integrity of the benefit rolls.



TAXES ON VIRGIN ISLAND SOURCE INCOME; DISABILITY BENEFITS

DECEMBER 21 (legislative day of DECEMBER 19), 1982.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 7093]

The committee of conference on the disagreeing votes of the two Houses on the Senate amendments numbered 2, 3, and 4 to the bill (H.R. 7093) to amend the Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Virgin Islands source income, to amend the Social Security Act to provide for a temporary period that payment of disability benefits may continue through the hearing stage of the appeals process, and for other purposes, and on the disagreeing votes of the two Houses on the House amendment to the Senate amendment numbered 1 to such bill, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 2, 3, and 4.

That the Senate recede from its disagreement to the House amendment to the Senate amendment numbered 1 and agree to the same with an amendment as follows:

In lieu to the matter proposed to be inserted by the House amendment to the Senate amendment, insert the following:

SECTION 1. INCOME TAX RATE ON VIRGIN ISLANDS SOURCE INCOME.

(a) IN GENERAL.—Subpart D of part III of subchapter N of chapter 1 of the Internal Revenue Code of 1954 (relating to possessions) is amended by inserting after section 934 the following new section:

“SEC. 934A. INCOME TAX RATE ON VIRGIN ISLANDS SOURCE INCOME.

“(a) GENERAL RULE.—For purposes of determining the tax liability incurred by citizens and resident alien individuals of the United States, and corporations organized in the United States, to the

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the Senate amendments numbered 2, 3, and 4 to the bill (H.R. 7093) to amend the Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Virgin Islands source income, to amend the Social Security Act to provide for a temporary period that payment of disability benefits may continue through the hearing stage of the appeals process, and for other purposes, and on the disagreeing votes of the two Houses on the House amendment to the Senate amendment numbered 1 to such bill, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

INCOME TAX RATE ON VIRGIN ISLANDS SOURCE INCOME

Present law.—The Virgin Islands Government contends that payments of passive investment income by V.I. persons to U.S. persons are subject to a 30-percent tax (on the gross amount of the payment) and a corresponding withholding obligation. Certain U.S. recipients of such income contend that such payments are subject to neither tax nor withholding. (Similiar payments to foreign persons are clearly subject to the tax and the withholding obligation.)

Senate position.—The Senate language (which is identical to the original House language) provides that the rate of V.I. tax on payments of passive investment income from V.I. persons to U.S. persons shall not exceed 10 percent. This treatment would apply to dividend payments out of earnings and profits accumulated in taxable years beginning on or after the date of enactment. The Government of the Virgin Islands would be able to reduce this 10 percent maximum rate in its discretion. The withholding obligation of the payer would in every case correspond to the substantive tax liability of the recipient. Payments to foreign persons would continue to be subject to the 30-percent tax and corresponding withholding.

House amendment.—The House amendment follows the Senate position, but makes two technical changes.

First, the House amendment makes it clear that Congress is taking neither side in the current dispute between U.S. persons and the V.I. Government by striking references to "reductions" in tax.

Second, the House amendment makes it clear that the Virgin Islands will be able to impose and require withholding of a tax of up to 10 percent on payments of passive income to U.S. persons.

Conference agreement.—The conference agreement follows the House amendment with the two technical changes.

CONTINUED PAYMENT OF DISABILITY BENEFITS DURING APPEAL

Present law.—A social security disability insurance (DI) beneficiary who is found to be no longer disabled under the provisions of the Social Security Act continues to receive benefits for two months after the month in which his eligibility is determined to have ceased. (As an administrative practice, individuals are now generally found to be “no longer disabled” no earlier than the month in which the individual is notified of the termination decision.)

The individual may request a reconsideration of the decision, and if the termination is upheld, he may appeal the decision to an Administrative Law Judge (ALJ). The individual is not presently eligible for benefits during the appeals process. However, if the initial termination decision is reversed, benefits are paid retroactively.

House bill.—Upon request of the beneficiary, DI benefits and Medicare coverage would continue to be paid through the month preceding the month of the decision pursuant to a hearing before an Administrative Law Judge. These additional DI benefits would be subject to recovery as overpayments, subject to the same waiver provisions now in current law, if the initial termination decision is upheld.

The provision is effective for benefit payments beginning with the first month after the date of enactment for cases where a termination decision has been made before October 1, 1983. In all cases such benefit payments would cease no later than June 1984. For cases where a termination decision was made before the date of enactment and a timely appeal is pending or is filed, benefits could be paid under this provision, but no lump sum back payments would be authorized.

Senate amendment.—Identical to House provision.

Cost effect.—According to the Congressional Budget Office this provision will increase outlays by \$75 million in fiscal years 1983–85. There are no costs beyond those years.

Conference agreement.—The conference agreement follows the House provision.

PERIODIC REVIEWS OF DISABILITY CASES

Present law.—The Social Security Disability Amendments of 1980 required the Secretary of Health and Human Services to review the cases of current disability beneficiaries at least once every three years, beginning in January, 1982, to determine whether they are still disabled. Beneficiaries judged to be permanently disabled were to be excluded from this review.

House bill.—The House bill authorizes the Secretary to slow down the number of cases sent to the State disability agencies for re-examination below the rate required by the 1980 amendments. The Secretary's determination of the appropriate numbers of cases to be reviewed in each State shall be based on consideration of the backlogs of such pending reviews, projected numbers of new applicants for disability benefits, and projected staffing levels of State

agencies. The State agency must demonstrate a good faith effort to meet appropriate staffing requirements and to process reviews in a timely fashion. The Secretary is to report annually to the House Committee on Ways and Means and the Senate Finance Committee on the determinations made under this section.

Senate amendment.—Same as House bill.

Cost effect.—Negligible.

Conference agreement.—The conference agreement follows the House provision.

REPORT BY SECRETARY

Present law.—There is no requirement for periodic reports to the Congress by the Secretary of Health and Human Services with respect to continuing disability investigations.

House bill.—Requires the Secretary of HHS to report to the Senate Finance Committee and the House Committee on Ways and Means semiannually on the number of: continuing eligibility reviews, termination decisions, reconsideration requests, and termination decisions which are overturned at the reconsideration or hearing level.

The provision is effective upon enactment.

Senate amendment.—Identical to House provision.

Cost effect.—None.

Conference agreement.—The conference agreement follows the House provision.

EVIDENTIARY HEARINGS IN RECONSIDERATIONS OF DISABILITY BENEFIT TERMINATIONS

Current law.—The Social Security Act provides for initial determinations of disability by the State agencies authorized by the Secretary to make disability decisions, and for continuing reviews of disability by the Secretary or the State agency. The law also provides for a hearing by the Secretary, and subsequent judicial review, for any individual dissatisfied with determinations made by the State agencies or the Secretary.

House bill.—The House bill requires the Secretary to provide, beginning no later than January 1, 1984, opportunity for a face-to-face, evidentiary hearing prior to reconsideration of decisions to terminate benefits for disability beneficiaries. This requirement does not supplant or affect in any way the requirement of existing law for a hearing by an Administrative Law Judge. The provision applies only to reconsiderations of determinations that the beneficiary is not disabled because the physical or mental impairment on which his eligibility is based is found to have ceased, not to have existed or to no longer be disabling.

Senate amendment.—No provision.

Cost effect.—Negligible.

Conference agreement.—The conference agreement follows the House provision.

CONDUCT OF FACE-TO-FACE RECONSIDERATIONS IN DISABILITY CASES

Present law.—The Social Security Act provides for initial determinations to be made by the State agency or the Secretary, and for hearings conducted by the Secretary and judicial review after such hearings for those individuals dissatisfied with the earlier decisions.

House bill.—The House bill requires the Secretary to take all steps necessary to insure public understanding of the importance Congress attaches to the face-to-face reconsideration hearings provided in Section 4. The Secretary is required to assure that beneficiaries will receive reasonable notice and information as to the time and place of the reconsideration, of the opportunities to be represented by counsel and to introduce evidence at the reconsideration, and of the importance of submitting all available evidence concerning the case at the reconsideration.

Senate bill.—No provision.

Cost effect.—None.

Conference agreement.—The conference agreement follows the House provision.

MEDICAL EVIDENCE

Present law.—Although current law does not specify a time period for the collection of medical evidence, current procedures, detailed in guidelines used by State agencies, require the Secretary to seek to obtain all medical evidence from all persons or institutions which have diagnosed or treated the individual within the 12-month period preceding the review of an individual's continuing eligibility.

Under both the regulations and the guidelines used by State agencies, an individual must meet the prevailing requirements for eligibility and no medical improvement needs to be shown to find an individual no longer eligible for disability benefits.

House bill.—No provision.

Senate amendment.—Requires the Secretary to make every reasonable effort to seek and obtain all relevant medical evidence from all persons or institutions which have diagnosed or treated such individuals with respect to his impairment or impairments within the preceding 12-month period. Requires the Secretary to consider all evidence available in the individual's case file relating to such impairment or impairments in making a determination on the case. States that nothing in the preceding sentence shall preclude the Secretary from finding an individual to be ineligible under the terms of the Social Security Act even if such individual's medical condition has not improved or otherwise changed since any prior determination of his disability.

Cost effect.—No estimate made.

Conference agreement.—The conference agreement does not include the Senate provision.

PUBLIC PENSION OFFSET

Present law.—Prior to 1977, social security spouse's benefits were available only to men, who could meet a dependency test and to

women, all of whom were presumed to be dependent. These provisions were declared in March 1977 (*Califano v. Goldfarb*) unconstitutional since they applied differently to men and women.

The Social Security Amendments of 1977 responded to the Goldfarb decision by providing, except for beneficiaries who are covered by the public pension offset exception clause, that social security dependents' benefits which are paid to spouses of retired, disabled, or deceased workers are reduced dollar-for-dollar by an amount equal to any public pension which the spouse receives as a result of his or her own employment by a Federal, state or local government which is not covered by social security. (Non-covered government employment is defined as employment not covered under section 210 of the Social Security Act on the last day the spouse was employed by the government.)

Under the exception clause (which expired December 1, 1982), the offset would not apply if: (1) a beneficiary is either receiving or eligible to receive a government pension based on non-covered employment for any month in the period December 1977 through November 1982, and (2) the beneficiary, at the time of filing for social security dependents' benefits, meets all the requirements for entitlement as they were in effect and being administered in January 1977. The law in January 1977 required men, but not women, to prove they were dependent on their spouses for at least one-half of their support in order to qualify for the spouse benefit.

House bill.—The House bill provides that during the 60 month period beginning with December 1982, the amount of the public pension used for purposes of the public pension offset shall be an amount equal to one-third of the public pension.

Senate amendment.—No provision.

Cost effect.—According to unofficial estimates of the Congressional Budget Office, the House bill would increase outlays by the following amounts (by fiscal years, in millions of dollars):

1983.....	15
1984.....	40
1985.....	65
1986.....	85
1987.....	108
1988.....	30

Conference agreement.—The Conferees agreed that, in lieu of a modification of the public pension offset clause, the public pension offset would not apply to an individual who becomes eligible for a public pension prior to July 1983 if that individual is dependent upon his or her spouse for one-half support. The one-half support test would be applied according to the pre-1977 law, except that it would apply to both men and women.

The amendment would also require the Secretary of Health and Human Services to study the pension offset provisions and to report his recommendation for any permanent legislation that may be appropriate by May 15, 1983.

In addition, the Conferees agreed to specify the definition of non-covered government employment as government employment

which on the last day the spouse was employed, was not covered employment for purposes of title II of the Social Security Act.

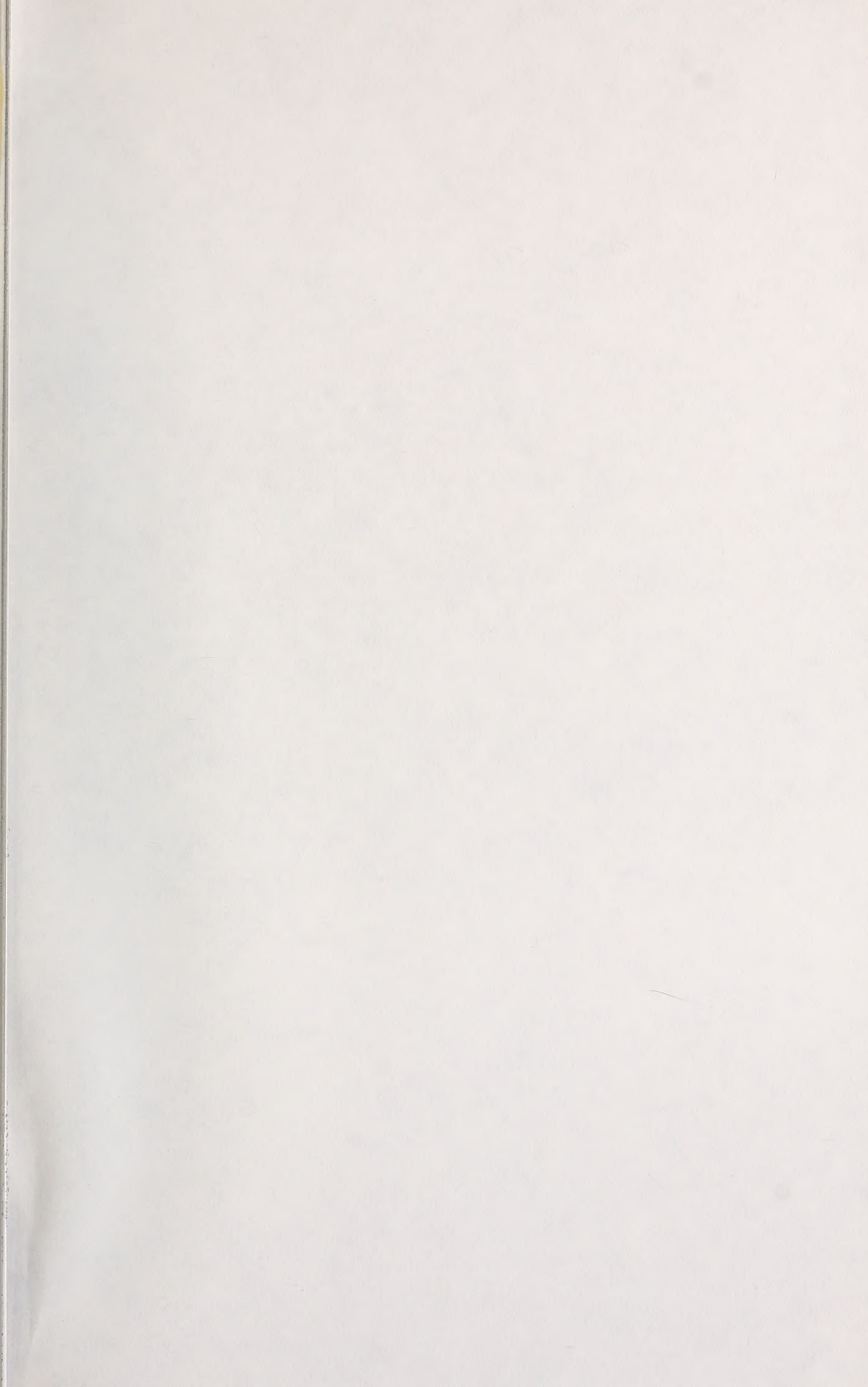
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